Please Type or Print in Black Indelible Ink. Assure All Copies Are I acidia

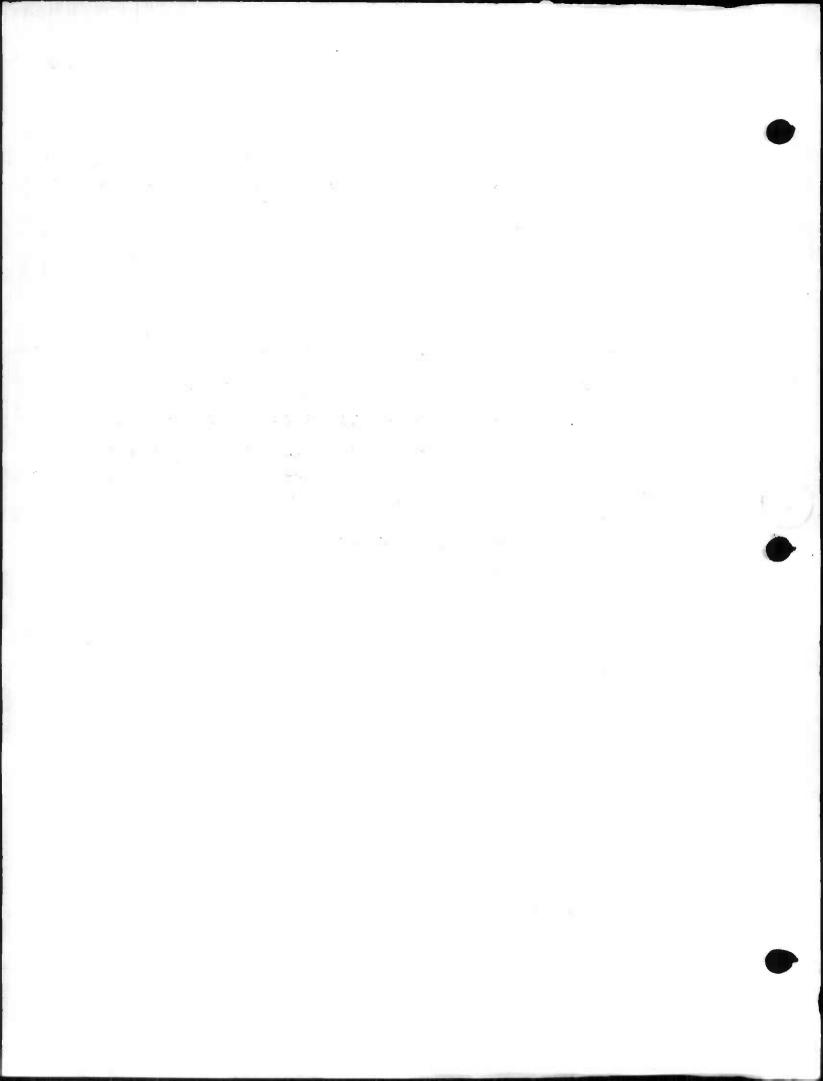
State of Maryland / Department of Health and Mental Hygiene 96 03501

| | | Decedant's Nama (First, Middle, L | ast) | | Cei | rtificate | Of L | <i>Death</i> | 2 Date | Reg of Deeth | . No. | | 3. Time of Death |
|---|----------------|---|--|--|--------------------------|--------------------------------|------------------|-----------------------------------|------------------------------------|----------------------------|---------------------------|-------------------------|--|
| Physic | | JOANN C. TAYLO | ŕ | | | | | | Mon | | Day 8, | Yaar 1996 | 0203 AM |
| /Med Exam | | 4e. Facility Nama (If not institution, g | | or) | | | 4 | b. City, Town, | | | 4c. County | | |
| Exam | ner | HARBOUR HOSPITA | | , | | | | ALTIMO | | | | | E CITY |
| Funera Directo | | 5. Sociel Security Number 6. 216-32-0371 Usual Rasidanca of Dacedant | 4 CO 4 4 CO 6 1 | Aga (In yrs. Ias | t birthday) Yrs. | If Under 1 Months I | Yeer | If Under 24 H Houra M | lin. (Mor | of Birth th, Day, Y | | | place (Steta or Foraign ntry) RYLAND |
| P & H | | 10a. Stata 10b. County | | 10c. City, | Town or Lo | cation | | | | | | 1 | 10d. Inside City Limits |
| the Marylar 28a-f show notified at | ğ | MARYLAND BALTI | MORE CITY | В | ALTIM | ORE | | | | | | | 1 X Yas 2 □ No |
| th the M or 28a-f s notifie | Director | 10e. Street and Number | | | | 10f. Zip C | ode | | | 10g | . Citizan of | What Cou | ntry? |
| th wit | a | 5708 JOHNSON STR | EET | | | | | 21225 | | | U | .S.A | |
| her dag | Funeral | 11. Maritai Stetus | 12. Was Daceder Armed Forces | 5? | 13. | Ves Decedar | nt of His | spanic Origin? n, Mexican, Pu | (Specify Yes | or No- | | ce - Ameri | can Indian, |
| to be | b | 1 Nevar Married 2 Married 3 Widowed 4 Divorced | | O No | | 1 □ Yes 2)X | Q No | Specify: | | , | | y: WH | |
| natural rigidal Ex | etec | 15. Dacedant's l (Specify only highast g | Education rada complated) | | 16a. Deced (Giva | lant's Usuai (kind of work | Occupa dona d | ition u <i>ring most of</i> t | working | 16 | b. Kind of B | usiness/In | dustry |
| Atthe han | Completed | Elamentery/Secondary (0-12) 12TH GRADE | Collega (1-4o | r 5+) | | LT MAN | | | | P | BANKIN | C | |
| Hygie ther ther | 8 | 17. Father's Neme (First, Middle, Las | (†) | | | DI IM | AGL | 18. Mothar's N | Jame /First A | | | | |
| d de | To Be | JOHN GOSNELL | • | | | | | | RINE L | | | ,,,, | |
| mant mant | F | 19e. Informent's Name/Raiailonship | (Type, Print) | | 19b. Mailir | na Addrass (S | Street a | n <i>d N</i> um <i>ber</i> or | | | | Stata Zii | n Code) |
| 20 m m m m m m m m m m m m m m m m m m m | | BILLY TAYLOR | | | | | | TREET | | | | | 1225 |
| of He of He | | 20a. Mathod of Disposition | | 20b. Pied | e of Dispo | sition (Nema | of | | 2 / Page | 1 | c. Location | | |
| Page nent n ary or | | 1 ☐ Burial 2 ☐ Cremelion 3 4 ☐ Donetion 5 ☐ Othar (Space | | a | | | | RPORAT | ION | | TOWSO | N | |
| permit. Page Department or Important: If I any injury or once. | | 21. Signature of Fundam Service Lice | ensee | 111 | | . Nama and | | | | | | | |
| 88258 | | 1 Tours | Z K | lus | - | | | IERAL H IS AVEN | • | | E M | 21 | 229 |
| No. | | 234. Part Liner the diseasa, or con mock or heart failure. List oni | nplications that cause | ed tha wath. | not ant | ar tha moda o | of dying | , such as card | lac or respira | tory arrest | L PIU | | Approximata interval Batwean |
| Physician | | | , | | | | | | | | | | Onsat end Death |
| /Medical Examiner | н | immediata Causa (Final diseasa or condition rasulting In death) | | netast | atic | lung | C | uncer | | | | | 1 year |
| Examine. | | rasuning in daa(n) | | Dua to (or a | | | | | | | | | - |
| nsit | Examiner | | b | | | | | | | | | | |
| tificate be executed g physician and as the burial-transit | Exal | Sequentially list conditions, if any, leading to immediate | | Dua to (or a | s a consaq | uence of): | | | | | | | |
| siciar buri | edicai | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Dieasas or Injury that initiated evants | C | Due to fee a | | | | | · | | | 1 | |
| certificate be executed ding physician and ise as the burial-transit | - | rasulting in daath) Last | d | Dua to (or es | s a conseq | uance or): | | | ٠ | | | | |
| v requires that the death cer been signed by the attendin should be detached for use | Physician/ | Dady of the state | 7.8-21-2-2-2-2 | | | | | 2011 - 100 100 | 1 | | | | |
| the d | hys | Part ii. Other algnificant conditione | contributing to death | but not rasulti | ng in tha u | nderlying cau | sa give | n in Pert i. | 231 | | | | o the cause of death' |
| ned t | by P | | | | | | | | _ | TE Tee | 2□ No | 3 🗆 Pro | bably 4 Unknow |
| v required been sig should b | P P | | | | | | | | 24a | Wes an a | | 24b. W | ara autopsy findings vallable prior to |
| aw re | piet | | | | | | | | - | performe | O r | CC | ompletion of causa death? |
| The law requires that the death cer ste has been signed by the attendin page 2 should be detached for use | Completed | | | | | | | | | 1 ☐ Yes | 2 No | 11 | □Yas 2ŒNo |
| | Be C | 25. Was casa ratarrad to medical axaminar? | | | | | | 26. Placa of 0 | Death (Check | only ona) | | | |
| 5 00 | To | 1 Yas 2 No | Hospital: | tlent 2 EF | VOutpatien | 1 3 M DOA | Othe | r: 4 🗆 Nursin | g Homa 5□ | Residano | a 6 □Oth | nar (Speci | (y) |
| ng Pl | | 27. Manner of Death 1 ☑ Natural 5 ☐ Panding | 28a. Data of in (Month, D | jury 28 | Bb. Tima of injury | 28c | . Injury Work | at ? | 28d. Das | cribe how | injury occur | red | |
| Attending or death. actor: Atter by the fune | cati | 2 ☐ Accident invastigeiii 3 ☐ Suicida 6 ☐ Could not | | | | M | 1 D Y | ′as 2□No | | _ | | | |
| or Attending I after death. Director: After I in by the funer | Certification: | 4 Homicida datamine | Zoa. Place of II | njury - At home atc. <i>(Specify)</i> | a, ferm, str | eat, tectory, o | office | | 28t. Loca City | tion (Street or Town, S | et and Numi Stata) | ber or Run | al Routa Number, |
| Pris de la | | 20a Casidian 40 a at 1 | | | | | | | | - | | | |
| To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edical | 29a. Cartifler 1 Certifying P (Check only one) 2 Medicai Exs | hysician: To the bes miner: On the besis and manners | of axamination | dga, daath and/or inv | occurred at a rastigation, in | my op | a, data and pla inion, daath o | ice, and dua to ocurred at that | o tha caus tima, data | sa(s) and m and piace, | annar as a and dua t | stated. o tha causa(s) |
| o the | ¥ e | 29b. Signature end titia of certifier | and mannar s | sidieu. | | 29c. L | icense | number | | 29d | . Data aigne | d (Month. | Day, Year) |
| - ≯⊨ ŏ | | In Att. | A - 44 N | | | | | 850 | | | | | 1996 |
| | | 30. Name and address of person who | completed seuse of | death (item 2) | Sa) (Type | | ノTリ | 000 | | FE | briar | 7 () | 01000 |
| | | | TTAVIANO - | | | | NCOI | LOGY-90 | 0 S. C | ATON | AVE-F | ALTTI | MORE MD |
| St | ate | 31. Data tilad (Month, Day, Year) | 32. Regis | trar's Signatur | 8 | | | | | | | | |
| Regist | | FEB 1 2 1996 | Lin Shulles | Rad- 11 | | | | | | | | | |
| | | 4 E D Z 15 15 15 | THE PERSON NAMED IN | TRANSPAR | | | | | | | | | |

DHMH 16 Rev 6/95

and the San War after

| | 1 - STATE REGISTRAR | STATE OF N | MARYLAND / CE | | ICATE | | | | MENTA | L HYGIENE REG. NO. | | | |
|----------------|---|---|--|-------------|-----------------------------|----------------|---------------|--------------------|----------------|-----------------------|---|--------------------------|---|
| | 1. OECEDENT'S NAME (First, Middle, DOROTHY | , | | TOE |)CD | | | | 2. DATE | Feb 8 | 000 | YEAR | 3. TIME OF OEATH |
| | 4. SOCIAL SECURITY NUMBER | MARIE 5. SEX | 6. AGE (In yrs. lest | | IF UNDER | 4 8540 | IF UNDER | | | OF BIRTH | 886 | | 8:15 pm _M |
| | 220-46-7267 | 1 M 2 F | | YRS. | MONTHS | DAYS | HOURS | MIN. | (Mont | th, Day, Year) | | Country | |
| | 9a. FACILITY NAME (If not institution, | give street and number) | 74 | | 9b. CITY, | TOWN O | R LOCATION | ON OF DE | | 3/22 | 9c. COU | NTY OF DI | YLAND EATH |
| 5 | Saint Joseph I | Medical Center | • | | | Toy | noev | Man | yland | 1 | | Baltim | |
| اۃ | RESIDENCE OF DECEDEN 10a. STATE 10b. CC | | | 40.01 | | | | | | 1 | | | |
| DIRECTOR | | BALTIMO | วต | | Y, TOWN O | | ION | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | MARYLAND 100. STREET AND NUMBER | DALITRO | XE. | | OWSOL | - | ZIP CODI | F | | | 10a CITI | ZEN OF W | 1 YES 24 NO |
| FUNERAL | 4 ECOWAY | | | | | 100 | 212 | | | | log. Giri | USA | THAT COUNTRY? |
| Š | 11. MARITAL STATUS | | T EVER IN U.S. AR | | 13. 1 | WAS DEC | | | IIC ORIGII | N? (Specify Yes | or No— | 14. RACE | American Indian. |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 | YES 2 X N | 10 | 1 | f yes, spe | | n, Mexica | n, Puarto | Rican, atc.) | | Black Specif | |
| | 15. DECEDENT'S | EDUCATION | 16a, DE | CEDENT'S | USUAL O | CCUPATIO | ON . | | 160 | b. KIND OF BUSI | NESS/INC | USTRY | WHITE |
| | (Specify only highest Elementary/Secondary (0-12) | grade completed) College (1-4 or 5 | life | Do NOT u | work done o se retired.) | during mo: | st of working | ng | | | 0 0 00000000000000000000000000000000000 | | |
| 뒫 | 11th GRADE | | · . | ERIC | AL A | DMIN | ISTR | ATOR | | OFFI | CE | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Las | 87) | | | | | 16. MOTI | HER'S NA | ME (First, | Middle, Maiden S | Surname) | | |
| BE | G. HERMAN HOFE | | | | | | | | | ORTRUP | | | 100 |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | | ber, City or Town. | | Code) | |
| | ALLAN P. TOBER | ? | | | RETO | | | ARN | OLD, | | 1012 | | |
| | 1 NBuriet 2 Cremetion 3 4 Donation 5 Other (Specify) | | 20b. PLACE A cemetery, cre. | maton/ or / | ther place! | | | D | 2/12 | 2/96 CO | | City or To | |
| | 21. SIGNATURE OF FUNERAL SERVI | | PODAME | JI V | 22. | NAME AN | O ADDRE | SS OF FA | CILITY | | | | |
| | * Christina | I. Kop | czyk | | | | ON F N, M | | LAL F 21286 | | 521 | LOCH | RAVEN BLVD. |
| | 23. PART I. Enter the diseases | , or complications the lure. List only one cau | t caused the de | ath. Do | | | | | | | alory an | reat, | Approximate |
| | iMMEDIATE CAUSE (Finel disease or condition resulting in death) | • | ABLE PSE | | MONA | S SE | PSIS | | | | | | Interval Between Onset and Death 4 DAYS |
| | resulting in death) | | (OR AS A CONSEC | | . , | | | | | | | | |
| Z | Sequentially list conditions, | b | RESSIVE | | | A | | | | | | | 15 MTHS |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | 506 10 | (OR AS A CONSEC | DUENCE C | IF): | | | | | | | | |
| E | CAUSE (Disease or Injury that initieted events | c. DUE TO | (OR AS A CONSEC | DUENCE O | IF): | | | | | | | | |
| | resulting in death) LAST | d. | | | | | | | | | | | |
| | PART II. Other significent con- | ditions contributing to | death but not r | esulting | in the un | derivlo | T CRUSA | given in | Part I | 24s. WAS AN | U/TOREV | 245 | WERE AUTOPSY FINDINGS |
| CAL | PANCYTOPEN | | | | | .com, mi | 9 00000 | givoii iii | | PERFORI | MED? | 240 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | 1 TYES 2 | Tub | | DF DEATH? |
| 2 | DID TOBACCO USE CO | ONTRIBUTE TO CA | USE OF DEA | TH Y | ES 🔲 I | NO [| UNC | CERTAIL | N \square | | | | I Cara Salva |
| NA I | 25. WAS CASE REFERRED TO MEDIC EXAMINER? | | 26. PLAC | E OF OEA | TH (Check | | | | | | | | |
| Sic | 1 TYES 2 THO | HOSPITAL: 1 () Inpetient 2 (| ER/Outpatient 3 | □ DOA | 4 Nur | | e 5 □ R | ealdenca | 6 🗆 Oth | er (Specify) | | | |
| PHYSICIAN: MED | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF (Month, D | INJURY Pay, Year) | 28b. TII | JURY | 28c. INJ WO | URY AT | | 28d. DE | SCRIBE HOW IN | JURY OC | CURED | |
| BY | 2 Accident Investiga | tion M 1 YES 2 NO | | | | | | | | | | | |
| COMPLETED | 3 Suicide 6 Could n 4 Homicide datarmin | or be building. | 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Rou City or Town, State) | | | | | | loute Number, | | | | |
| ا <u>د</u> | 29a. CERTIFIER (Check only | PHYSICIAN: To the best of | my knowladge, de | ath occur | red at the t | lme, data | end place | a, and due | to the ca | ruse(a) and men | ner se sta | ted. | |
| ∑ | nna! | | the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) are beele of examination end/or investigation, in my opinion, death occurred at the time, data and p | | | | | | | | | a) end menner as stated. | |
| BEC | 296. SIGNATURE AND TITLE OF CER | RTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNED | | | | | | (Month, Day, Year) | | | | | |
| 10 B | Industr. | r multa | MO | | | | D | 4141 | 0 | | 15 | ebua | ry 9th, 96. |
| - | 30. NAME AND ADDRESS OF PERSON | | | | | TOW | SON | MAF | RYLAI | VD 2120 | | | 1 |
| | 31. DATE FILED (Month, Day, Year) | | AR'S SIGNATURE | , | | | | | | | - | | |
| | FEB 1 2 1996 | grund Davidson | n-Handell | | | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 96

03503

| | | | | | $C\epsilon$ | ertifica | ite of | Death | | Reg. No. | | 33303 |
|--|-----------------|---|------------------------------|---------------------------|--------------------------------|---------------------------|-----------------------|--------------------------------------|---|-------------------------|--------------------------------|-------------------------------------|
| Dhootst | | 1. Decedent's Neme (First, Middle, L | ast) | | | | | | 2. Dete of De Month | | Vess | 3. Time of Death |
| Physicia: /Medica | _ | DANIEL PAUL | WORTHI | NGTON | JR. | | | | FEB. | 09, 1 | 996 | 1:57 PM |
| Examine | - | 4a. Facility Neme (If not Institution, g | ive street and nu | m <i>ber</i>) | | | | 4b. City, Town, o | r Location of Deeth | | | |
| | | SHOCK TRAUMA | 1 | | | | _ | BALTI | 1ORE | N/A | | |
| Funeral Director | | 5. Social Security Number 6. 213-26-2418 2 13-26-5862 | Sex 1 M 2□ F | 7. Age (In yrs | . last birthdey Yrs. |) If Und Months | er 1 Yeers Deys | | | th y, Year) -1931 | 9. Birthpla Country MARY | ce (Stete or Foreign y) LAND |
| > | - | Usuel Residence of Decedent 10a, Stete 10b, County | | 400.0 | | | | | | | | |
| nottled at | _ | | | 100.0 | ity, Town or L | | T. | | | | 100 | d. Inside City Limits |
| - SE | Funeral Directo | | | | BALT | | | | | | | 1X Yes 2 □ No |
| 2 2 | 5 | 10e. Street and Number | | | | 7 | ip Code | | | 10g. Citizen of | | y? |
| 23a o | ā | 832 REVERDY F | | | | | 212 | | | U.S.A | | |
| Dec.m | Š | 11. Meritel Stetus | Armed Fo | edent Ever in U prces? | J,S. 13. | Wes Dec | edent of ecify Cul | Hispenic Origin? ben, Mexican, Pu | (Specify Yes or No erto Rican, etc.) | | ce - Americar ck, White, et | |
| 0 📓 📗 | by F | 1 Never Married 2 Merried | 1 M Yes If Yes, Gi | ve | | 1 Yes | 2 No | Specify: | | Specif | hv- | |
| <u>-</u> | | 3 Widowed 4 Divorced | Yeer or D | Detes: | | | | | - | | WH | ITE |
| ofical Ex | Completed | 15. Decedent's E (Specify only highest g | Education rade completed) | | 16a. Dece (Give | edent's Us e kind of w | uel Occu | ipation e during most of и ed) | orking | 16b. Kind of B | lusiness/Indu | stry |
| The Ma | E | Elementery/Secondery (0-12) | College (| 1-4or 5+) | 100 | | | | | | | |
| vent, the Mo | ဒ | 12 | 43 | | PRE | S. F | .оор | 1 | RAGE CO | | | RAGE |
| 200 | e n | 17. Fether's Neme (First, Middle, Las | | I C T C L | an. | | | | eme (First, Middle, | Meiden Surner | ne) | |
| marked imatic e | 0 | DANIEL PAUL V | | IGTON | | | | 1 | POWERS | | | |
| o € | | 19e. Informent's Neme/Reletionship | | .cme.ii | j | | | | Rurel Route Number | | | iode) |
| other t | | VIRGINIA A. V | ORTHIN | | | | | Y RD. I | BALTO.,N | | | |
| o off | | 20a. Method of Disposition 1 ■ Buriel 2 □ Cremetion 3 | Removel from | | Plece of Disp cemetery, cre | | | ece) | Dete | 20c. Location | - City or Tow | n, Stete |
| ury | | 4 □ Donetion 5 □ Other (Spec | | S | T. MA | RYS | CEM | ETERY 2 | 2/13/96 | BALTO | .,MD. | |
| important: If is any injury or once. | | 21. Signeture of Funerel Service Lice | nsee | | | | | ess of Fecility | | | | |
| ESS | | Mal Mismory | 200 | 70 | | | | | INS & SO | | | |
| | - | 23a. Part 1. Enter the disease, or cor | nplications that | aused the dee | th. Do not er | 4905 | y O | RK RD. | BALTO. | MD 2 | 1212. | Approximate |
| sician | | shock, or heert fellure. List only | one ceuse on e | each line. | | | , | | ar or respiratory of | , | 1 1 | nterval Between Onset and Deeth |
| dical | | Immediate Cause (Final | / | W-14 | 11- 1 | - 1 - | 4-1 | | | | | |
| niner | - | disease or condition resulting in deeth) | θ | Notti | PRI | -77)(| 4001 | 25 | | | | |
| | 5 | | | Due to (| or es e conse | quence of | 1): | | | | į | |
| 13 E | | | b | | | | | | | | | |
| fel-transit | X | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | | Due to (| or as e conse | quence of |): | | | | i | |
| pod 1 | | Cause (Disease or injury | c | | | | | | | | i | |
| se es the bu | 200 | thet initieted events resulting in deeth) Last | | Due to (| or es e conse | quence of |): | | | | i | |
| 80 0 | 2 | | d | | | | | | | | i | |
| for use es the buriel-transit | 0 | | | | | | | | | | | |
| detached for use | Friysician | Pert II. Other significant conditions | contributing to d | eath but not re | sulting in the | underlying | cause g | iven in Pert I. | 23b. Did i | lobacco uss co | ontributs to t | he cause of death? |
| detac | | | | | | | | | 10 | Yes 2 No | 3 Probe | bly 4 Unknow |
| 2 2 | 2 | | | | | | | | Dustre | | | |
| pege 2 should | 20 | | | | | | | | | en autopsy med? | eveil | e autopsy lindings able prior to |
| 70 2 sl | 2 | | | | | | | | | | | pietion of cause eath? |
| eged | 5 | | | | | | | | 10 | res 2 No | 10 | Yes 2□No |
| rector, pe | | 25. Wes case referred to medical | | | | | | 26. Piece of D | eeth (Check only o | ne) | | |
| - C | 0 | exeminer? 1 ∑ Yes 2□ No | Hospitel: | Inpatient 25 | ER/Outpatie | int 3□ 0 | OA O | ther: | Home 5 ☐ Resid | | ner (Specify) | |
| 70 | | 27. Menner of Deeth | 28e. Dete | ol Injury | 28b. Time | | 28c. Inju | | 28d. Describe | | | |
| ed in by the funer | 200 | 1 □ Neturel 5 □ Pending investigation | | th, Day Year) | Injury | М | | ork? Yes 2 □ No | FUI NO | 1ist can | Wan C | hae |
| by the | 2 | 3 Suicide 6 □ Couid not | 28e. Piece | of Injury - At h | nome, ferm, si | | | | 28f. Location (S | | ber of Rural P | Route Number. |
| d in by the | 5 | 4 Homicide | buildi | ng, etc. (Speci | fy) | , | 3 | 5 | City or Tov | vn, Stete) | 600 | 7.7 |
| 100 | | 29e. Certifier 1 Certifying P | | VELOUS best of my kno | | th occurre | d et the t | ime, dete and nie | ce, end due to the | cles 99 | anner es stat | ted. |
| pletely fi | 2 | | minar: On the ba | asis of examine | etion and/or in | rvestigetio | n, in my | opinion, deeth oc | curred et the time, | dete end plece, | end due to the | he cause(s) |
| orthe Funeral Dompletely filled | | 29b. SignerU/Prend title of certifier | 1 | 1 | | 29 | 9c. Licen | se number | | 29d. Date signe | ed (Month De | av Yearl |

29c. License number

O.C.M.E.

se of deeth (item 23e) (Type, Print)
111 PENN ST. BALTO., MD. 21201.

29d. Date signed (Month, Day, Year) FEB. 10,1996

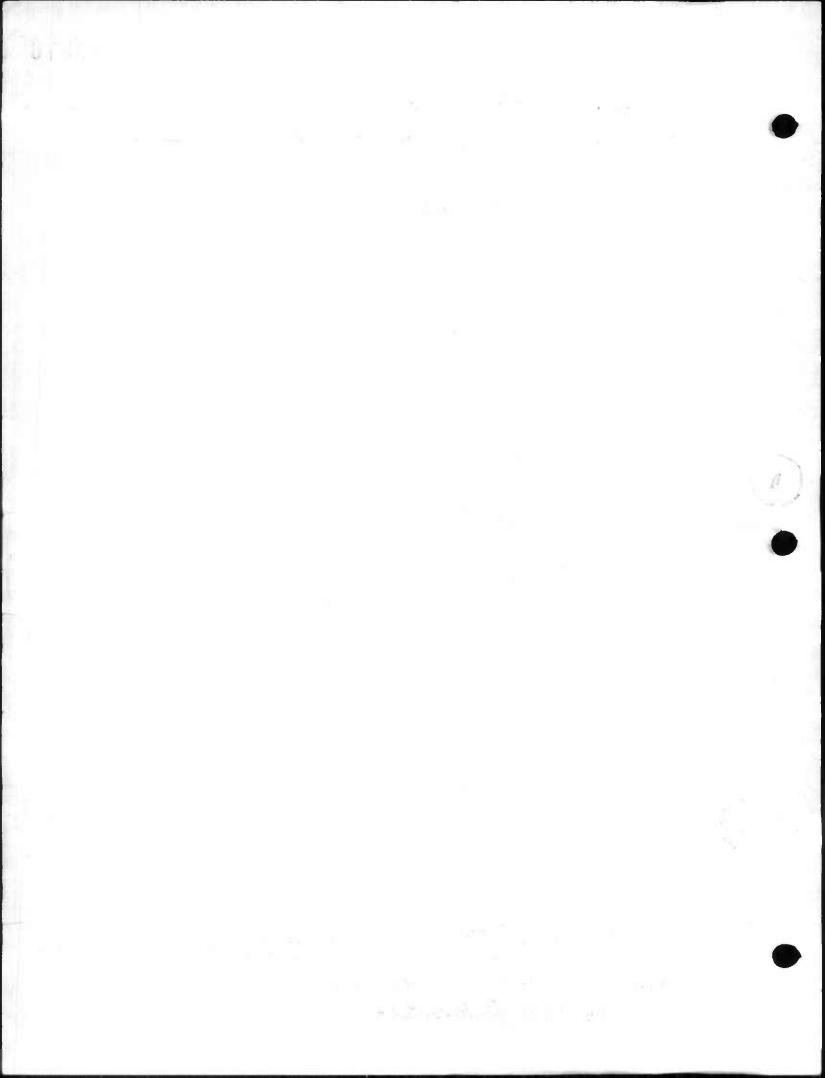
State Registrar

.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

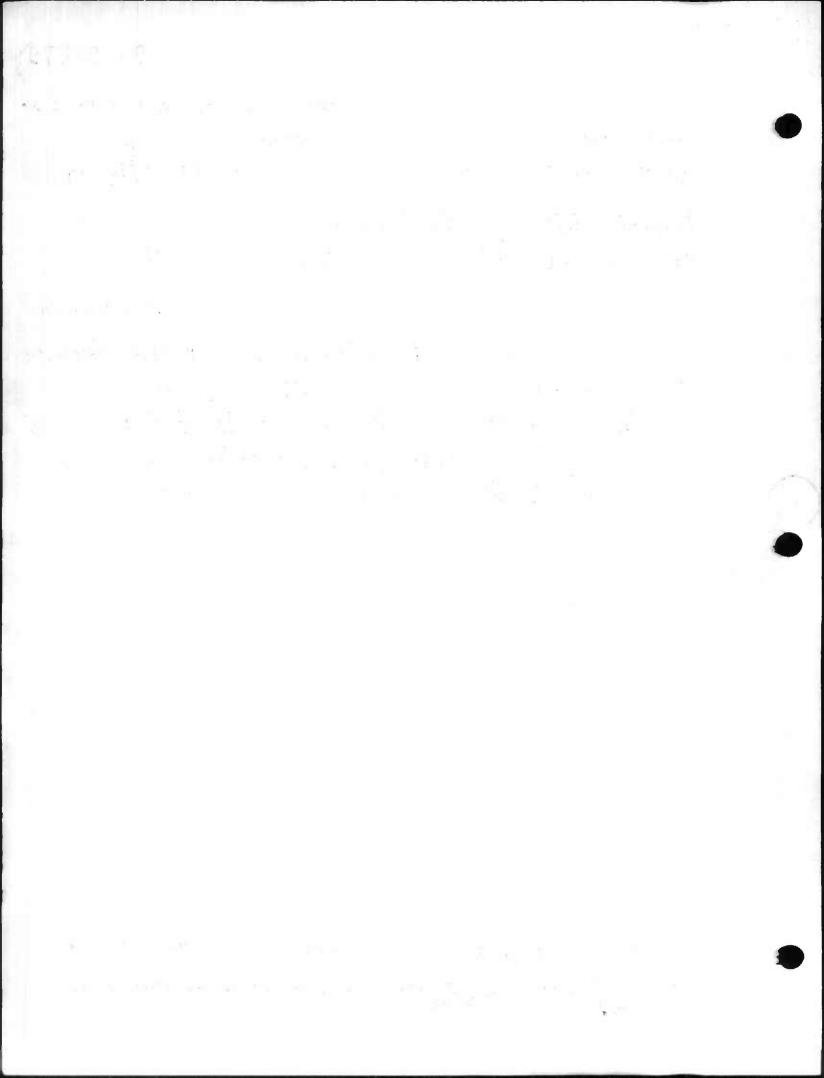
State of Maryland / Department of Health and Mental Hygiene 96 03504

| | | | Filmg, 732, item | n #4¢, 2/12 | /96,cy | w Cert | ificate of | Death | | Reg. No | , , , | | | 04 |
|----------------------------|--|----------------|---|-----------------------------------|----------------------------|----------------------------|---|---|--|-----------------------------------|---------------------------|---------------------------|--|------------------|
| | | | 1. Decedent's Neme (First, Middle, L | ast) | | | | | 2. Date | of Deeth | | 10000 | 3. Time | of Death |
| d. | Physic | | Laura | Wat | - 50 | N | | | Feb | | | Yeer Y46 | 8:4 | 5 PM |
| | /Medi Examir | | 4e. Fecility Neme (If not institution, gi | ive street end number) | | | | 4b. City, Tow | n, or Location of I | | . County of | | 0. |) ' |
| 1 | | | Harbor Hospi | tal 3001 | south | Han | re rove | | more | A | 4 | | N/A | |
| | Funeral Director | | 241-32-0821 | Sex 7. Age | e (In yrs. last i 86 | Yrs. | If Under 1 Yeer Months Days | | Min. (Mont | of Birth h, Dey, Year, 19,1 | 909 | 9. Birthpl Count NC | lace (Stete try) | or Foreign |
| | D | | Usuel Residence of Decedeni 10e. Stete 10b. County | | 10c. City, To | wn or Loc | ation | | | | | 1 | 0d. Inside (| City Limite |
| | of the last | 5 | | 0 | | | ation | | | | | | | s 2 □ No |
| | the A | Director | MD N/. | A | BALTI | MORE | 10f 7lp Code | | | 100 0 | Alman - 6 24 M | | ^ | |
| | E 0 4 | ក្ | | | | | 10f. Zlp Code | | | log. Ci | tizen of Wh | | try r | |
| | after death with the Maryland or thems 23s or 25s-f show unions must be notified at | Funeral | 1203 SCOTT STREE | 12. Was Decedent B | Ever in II S | 12 W | | 21230 | in? (Cassifir Vac | ne Ma | USA 14. Race - | | an Indian | |
| _ | hard iner | P. | 1 Never Merried 2 Merried | Armed Forces? 1 ☐ Yes 2 ☐ N | | 15.16 | Yes, specify Cub | an, Mexican, | in? (Specify Yes of Puerto Rican, etc | i.) | | White, | | |
| 21215-0020 | hours after tural, or its at Examina | by | 3 ☑ Widowed 4 ☐ Divorced | If Yes, Give X Yeer or Detes: | | 11 | □Yes 2 No | Specify: | | | Specify: | LHIT | T C | |
| 9 | 72 hox natura dical E | | 15. Decedent's E | Education | 16 | Sa. Decede | ent's Usuel Occup | petion | | 16b. K | (Ind of Busi | WHI iness/ind | | |
| 215 | within 7, nne. Ithen "n he Medi | Completed | (Specify only highest gi Elementery/Secondary (0-12) | | | (Give k | ind of work done O NOT use retire | during most | of working | | | | , | |
| 21 | d with | EO | 12 | College (1-4or 5 N / A | +) | FAC | TORY WOR | KFR | | T | IE COM | MPAN | ٧ | |
| | of the file | Be C | 17. Father's Name (First, Middle, Las | t) | | | . Contraction | | 's Name (First, M | | | | | |
| Maryland | Ments Ments riced tice | TOE | CLAUDE WATSON | | | | | NINA | ARNOLD | | | | | |
| an | and h | | 19e. Informant's Name/Reletionship | (Type, Print) | 1 | 9b. Melling | Address (Street | t end Number | r or Rural Route N | lumber, City | or Town, S | tete, Zip | Code) | |
| ≥. | art fr | | RUBY GREEN (DAUG | HTER) | | 1203 | SCOTT S | TREET. | BALTIMO | RE. MI | 21: | 230 | | |
| ore | 20年 日 | | 20a. Method of Disposition | | 20b. Plece ceme | of Disposi | ition (Neme of story or other pla | ice) | Dete | 20c I | ocation - C | | wn, Stete | |
| Ě | A min | | 1 ☐ Burial 2 ☐ Cremetion X 5 4 ☐ Donation 5 ☐ Other (Speci | XI Hemovel from State | BEAV | ER H | CLL CEME | TERY | 2/12/9 | 6 FDI | ENTON | . NC | | |
| # | THE STATE OF | | 21. Signature of Funeral Service Lice | risee | 1 | | | | FUNERAL | | | , 110 | | |
| | | | 1/3 an/1/1 | | | | | | I FUNEKAL T, ELKRI | | MD 2 | 1227 | | |
| | | | 23e. Pert1. Enter the disease, or conshock, or heart feilure. List only | nplications thet caused | the deeth. D | | | | | | 1D Z. | 1221 | Approxime | ele . |
| | Physician | | shock, or need reliate. List only | y one cease on each lin | 9. | | | | | | | 1 | Onset and | Deeth |
| a | /Medical | | Immediate Cause (Finei disease or condition | ASP | i G. H | 010 | Phe | 41110 | Nia | | | | 51 | ~~ |
| н | Examiner | | resulting in deeth) | | Due to (or as | | | 1 4 4 4 | il I | | | |) = " | 93 |
| | 2 5 | Examiner | | b_Conge | Tivo | U | ourt | Failu | ire | | | 5 | 5 7V | |
| | certificate be executed nding physician and use as the buriel-transit | Kam | Sequentially list conditions, | | Due Io (or es | a consequ | ence of): | | | | | | 9. | |
| 68760, | cian cian | | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | chronic | di: | 1/140 | tive | Pr/m | 0000 | Dis | CH | 2011 | 0 - | tri |
| 87 | ohysi the t | Medical | that initiated events resulting in death) Lest | | Due to (or es | conseque | ence of): | | U | | | | | 0. |
| × | certification of the second of | | L | d | | | | | | | | į | | |
| Bo | eth for | Physician/ | | | | | | | | | | i | | |
| P.O. | 0 0 0 | iysl | Pert II. Other significant conditions | 1 | | in the und | derlying cause gi | ven in Pert I. | 23b. | Did tobacco | | | | - |
| | law requires that the as been signed by the 2 should be detache | by Pł | Diabetes | rellity | > | | | | | 1 Yes | ≧∐ No 3 | I Prob | nebly 45 | ⊉ Unknown |
| Division of Vital Records, | quire; n sig uld b | | Dementi | | | | | | | Wes an auto | ppsy | 24b. We | ere eutopsy | findings |
| ပ္ပ | aw requires is been si 2 should | Completed | Demen 1 | 9 | | | | | | performed? | | con | allable prior apletion of deeth? | |
| æ | 0 - 5 | E O | | | | | | | | 1 □ Yes 2 | No | | | No |
| ita | in: The | Be C | 25. Wes case referred to medical | | | | | 26 Piace | of Deeth (Check of | 10.5 | | | 3.00 20 | |
| >/ | ol and | To | examiner? 1 ☐ Yes 2 ☐ No | Hospitel: | n 2□ER/0 | Dutpatient | 3□ DOA Ot | har | sing Home 5 | | 6 □Other | (Specify | () | |
| 0 | E S | | 27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending | 28e. Dete of Injur (Month, Dey | y 28b | . Time of Injury | 28c. Inju Wo | ry al | 28d. Desc | ribe how Inju | ry occurred | d | | |
| Ö | Attending ir deem seton in by the | atle | 2 Accident investigation | on | | ,, | | Yes 2□N | lo | | | | | |
| Ξ | after d Direct | Certification: | 3 Suicide 6 Couid not t 4 Homicide determined | | ry - At home, (Specify) | ferm, stree | et, fectory, office | | 28f. Locat City o | ion (Street a | nd Number | or Rura | / Route Nu | mber, |
| | urs after ral Dir illed in | | | | | | | | | | | | | |
| | To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by | edical | 29a. Certifier 1 Certifying Pi | hystolan: To the best of | exeminetion e | ge, deeth o end/or inve | occurred et the ti estigetion, in my o | me, dete end opini <i>on</i> , deeti | plece, end due to n occurred et the t | the ceuse(s lme, dete an |) end mann d plece, an | ner as st d due to | eted. the cause | (s) |
| | To the within 2 To the comple | Mec | 29b. Signeture end title of certifier. | and menner sta | - 15 | | 29c. Licens | se number | | 29d D4 | ete signed (| (Month i | Day Year | |
| | 5 the Co | | | abasi 00: | - 120 | 250 | | | 1436 fil | er F | | 3.1 | A 18 | 0/ |
| | 7 | | 30 Name and address of second to | 1.480 | Cev |) (T C | | | | | eb. | | () | 76 |
| | | 1 | 30. Name and address of person who | TABAS | | ay box | | ital (| center | Bal | timo | Vo. | MI | |
| | Sta | te | 31. Dete filed (Month, Dey, Year) | | r's Signature | | 151 | .,,,, | | 091 | .,,,,,, | | | |
| | Registr | | FFR12 | 1996 | Muslage | Saul. | dl- | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | | State of Marylar | | t of Health and e of Death | | ene 9 6 L g. No. | 13505 |
|---------------------|---|----------------------------------|--|--|---|--|--|--|--|
| | Physic | ian | Decedent's Name (First, Middle, Last T. T.N.L.T.O.O.D. |) | | | 2. Dete of Deeth Month FEBUARY | °79 1996 | 3. Time of Deeth |
| | /Medi Examii | cal | LINWOOD 4a. Facility Nama (If not institution, giva 4121 FAIRFAX RO | | | | r Location of Deeth | C 09 1996 | |
| | Funeral Director | | 5. Social Security Number 6. Se 18 - 42 - 5/42 | | lest birthday) If Under Months | BALTIN 1 Yaar If Under 24 Hr Days Hours Mir | s. 8. Data of Birth | 1944 Ma | Tolace (State or Foreign unity) |
| Maryland 21215-0020 | be filed within 72 hours after death with the Maryland tall Hyglene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be incitiled at | Be Completed by Funeral Director | Usuel Residence of Decedent 10a. State 10b. County 10e. Street and Number 11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest gred Elementary/Secondery (0-12) 17. Fathar'a Name (First, Middle, Last) | 12. Wes Decedant Ever In U Armed Forces? 1 Yes, Give Yeer or Detes: | If Yes, spec | Coda 2/2/6 lent of Hispenic Origin? (iffy Cuben, Mexican, Pue 2/2/No Specify: of Occupation th done during most of we be retired) | Specify Yes or No- rto Rican, etc.) | g. Citizen of Whet Col 14. Rece - Amer Bleck, White Accity 3b. Kind of Busineas/1 | a rican indien, o, atc. American |
| Baltimore, Maryla | permit. Peges 1 and 2 should be Department of Heelth and Mental Important: If item 27 is marked c any injury or other traumatic ev. pdcs. | To | 19e. Informent's Name/Ralationahip (7) 20a. Method of Disposition 1 Dr Buriel 2 Cremetion 3 Dr 4 Donation 5 Other (Specify) 21. Signature of Funerel Service Licens 23a. Part/ Entar tha diseasa, or completed the complete of the comple | Smith Removel from Stele Removel From Stele Removel From Stele | 4019 Par Place of Disposition (Nematary, cremetory pro | MOTIAL MOTIAL d, Address of Fecility h L. RUS W. North | 5 Ave. 1 2/14/96 7 5 Fune | Balto, M Balto, City or 1 Balto, C eral Ho | d. 2)215 Town, Stata 0, Md. me 21216 Approximeta |
| | Physician /Medical Examiner | | Immediate Causa (Final disease or condition resulting in death) | · Antonoscu | ENOTIC GOOD or es a consequence of): | | | | intervel Between Onset and Deeth |
| Box 68760, | death certificete be executed e ettending physician and of for use as the burial-transit | n/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c | or es e consequence of): | | | | |
| P.0. | by th | Physician/M | Part ii. Other significant conditions cor | tributing to death but not res | uiting in the underlying o | euse given in Pert i. | | | to the cause of death? |
| of Vital Records, | hes been sign pe 2 should be | Completed by | | | | | 24a. Was en a performe | con s | Were autopsy findinga available prior to completion of ceusa of death? |
| Division of Vital | or Attending Physician: after death. Director: After this certific in by the funerel director, | Certification: To Be C | 25. Wes cese referred to medical exeminer? 152 Yes 2 No 27. Menyrer of Deeth 112 Neturei 5 Pending investigation 3 Suicida 6 Could not be determined | dospitel: 1 inpatient 2 inpati | M Mome, farm, street, fectory | A Other: 4 Nursing Bc. Injury et Work? 1 Yes 2 No | Horna 5XX Residence 28d. Describe how | ce 6 Other (Special Injury occurred | offy) |
| | To the Hospital within 24 hours a To the Funeral I completely filled | Medical C | 29b. Signature end title of certifier | alclan: To the best of my kno ner: On the besis of examinal and menner steted. | tion end/or invastigetion, | et tha time, dete end place in my opinion, deeth occur. License number O . C . M . E . | curred at tha tima, dete | se(s) end manner as e end plece, and due d. Dete signed (Month CBUARY 10 | to the ceuse(s) |
| | | | 30. Name and addrass of person who co | omplated cause of death (itam | | eet, Balti | imore, Ma | ryland 2 | 21201 |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

| F. | IF FUNRAL DRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should | of within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | NFTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by til | be filed within 72 hours after death with the State Dept. of Health and It | IMPORTANT: If item 28 is marked, or item 23 shows any In- |

SRIHARS HA

31. DATE FILED (Monito, Day, Year)

FEB 1 2 1996

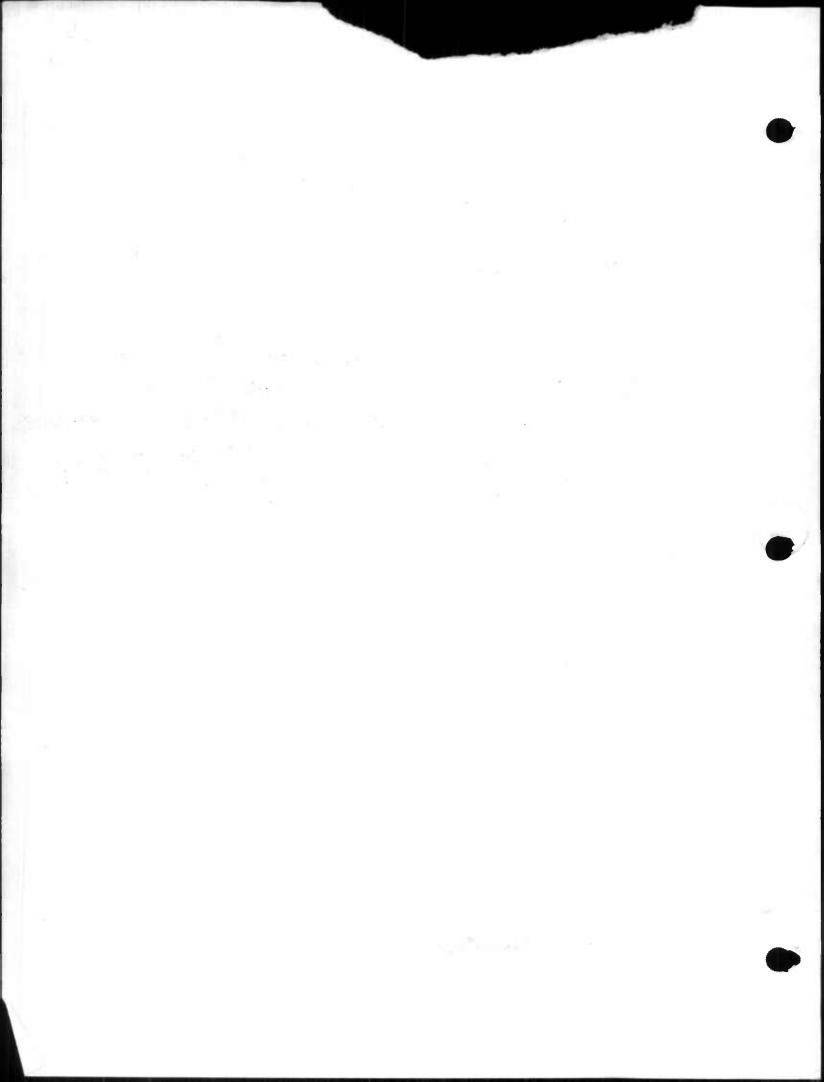
| | | | | | | 95 | 03505 |
|-------------|--|---|-------------------------------------|--|--|---|---|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / | | T OF HEALTH AND E OF DEATH | MENTAL HYGIEN | | |
| | 1. DECEDENT'S NAME (FIRST MICHIGO, Last) CUALTS PULLNE 4. SOCIAL SECURITY NUMBER 215 40 4990 | M Wewer 5. SEX 1 M 2 D F SO | et birthday) IF UNDE YRS, MONTHS | A 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 2. DATE OF DEATH | eight, / | 3. TIME OF DEATH 94 OAS AM BIRTHPLACE (State or Foreign COUNTY) |
| TOR | 98. FACILITY NAME (If not institution, gire st A 15 ON 55 RESIDENCE OF DECEDENT | WERA / HOSPITA | 9b. CIT | FAILS 10N | EATH | 9c. COUNTY | OF DEATH RFORD |
| DIRECTOR | 10e. STATE 10b. COUNTY | RFORD | 10c. CITY, TOWN | OR LOCATION SELVATO | | | 10d. INSIDE CITY LIMITS? 1 YES 2 10 |
| FUNERAL | 100. STREET AND NUMBER 1016 SWAT | ON CRESTA | POTB | 2104 | 10 | 1 | OF WHAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 1 1 ES 2 1 IF YES, GIVE WAR OR DATES | | . WAS DECENDENT OF NISPA If yes, specify Cuben, Maxic 1 YES 2 NO Speci | an, Puerto Rican, etc.) | s or No — 14. | RACE — American Indian, Black, White, atc. |
| OMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | completed) (G College_41-4 or 5+) | . Do NOT use retired., | during most of working | | SINESS/INDUST SURBA | SERVICE |
| BE COI | 17. FATHER'S NAME (First, Middle, Last) | AVER | | SAT | AME (First, Middle) Melder | DIN DIN | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) DVB/VV B 20a. METHOD OF DISPOSITION | NEAVER / | 1016 Su | A OW CYBL | 7 157,3 | un, Stata, Zip Co <u>5066U</u> Ocation — City | 100 MD, 21046 |
| | 20a. METHOD OF DISPOSITION 1 | 1 /// | AND DATE OF DISPA | REMATURY | 2/19/1 8 | 417,1 | nD, |
| | Jonn MM | and | | CAPRY POST TO | ARCH FUN | SPA/1 | TMD 2122 |
| | 23. PARTY. Enter the diseases, or chock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | complications that caused the de List only one cause on each line VEPT | 0. | | ch as cardiac or real | TON | Approximata interval Batween Onset and Death |
| NO | Sequentielly list conditions, | DUE TO (OR AS A CONSE. DUE TO (OR AS A CONSE. OUE TO (OR AS A CONSE. | MICC | ARDION | 170PA | THY | FEW HONTH |
| RTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | DIABE DUE TO (OR AS A CONSE | TES | MELLIT | US | | FEWYEARS |
| MEDICAL CE | PART II. Other algorificent condition | a contributing to death but not a | resulting in the u | inderlying ceuse given in | | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO |
| SICIAN: I | DID TOBACCO USE CONTI | | ATH YES CE OF DEATH (Check | | IN 🗷 | | |
| SICI | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 | OTHE | | 8 Other (Specify) | | • |
| ву РНҮ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. OATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. OEŞCRIBE HOW | INJURY OCCUR | ED |
| ETED | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, tarm, atreet, fa | ctory, office | 281. LOCATION (Street City or Town, Stets | and Number or i | Rurel Route Number, |
| COMPL | ann) | CIAN: To the best of my knowledge, de R: On the bests of examination and/or | | | | | ause(s) and menner as stated. |
| O BE | 296. SIGNATURE AND TITLE OF CERTIFIER STUDYSHO | veling H.D. | | 29c. LICENSE NI D0048 | MBER 754 | | IGNED (Month, Day, Year) PUART 8, 1996 |
| | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEATH (ITE | M 27) (Time Print) | | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

SRIHARSHA VELURY M.D. 2112 BELAIR ROAD, FALLSTON

32. REGISTRAR'S SIGNATURE

OHMH-16 Rev 1/89



| HYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician. It is a should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mertal Hygiene prior to burial, cremation, or removal. |
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|---|

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 3 15 P illiam amlan Z 4. SOCIAL SECURITY NUMBER 219-30-2511 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, You B. BIRTHPLACE (State or Foreign DAYS 1 XM 2 - F 60 YRS. 114 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH N / A 5 - agres
RESIDENCE OF DECEDENT DIRECTOR Hospita Bachmore 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Ferndale 1 YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 11 Emerson Avenue 21061 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No If yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES BY 1 TES 2 NO Specify Specify: 3 Widowed 4 Divorced Korean Conflict White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Policeman Policeman Police Dept. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnam Herbert Amland Catherine Cochran BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Amland 11 Emerson Avenue Ferndale, Maryland 21061 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Buriel 2 Cremetion 3 | Loudon Park Cemetery 4 Donation 5 Other (Specify) 2/13 Baltimore, Maryland 21. SIGNATUBE/OF FUNERAL SERVICE LICENBEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. namuous 4001 Ritchie Hwy. Baltimore, Md. 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line. Interval Betwee IMMEDIATE CAUSE (Final Onset and Death disease or condition tachy card · ventralar reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) coronan CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING bronchiolins CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24h WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MS 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🔯 NO 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident
3 Suicide 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide determined 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) end manner as stated COMPL 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner ee stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 040690 endy 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ST. Agnes Hosp

2. REGISTRAR'S SIGNATUR Davilson Re

ubin

Jensi

31. DATE PILED (Month, Day, Year)

BAITIMORE,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any hours after death. Page 6 may be retained by the hospital or attending physician.

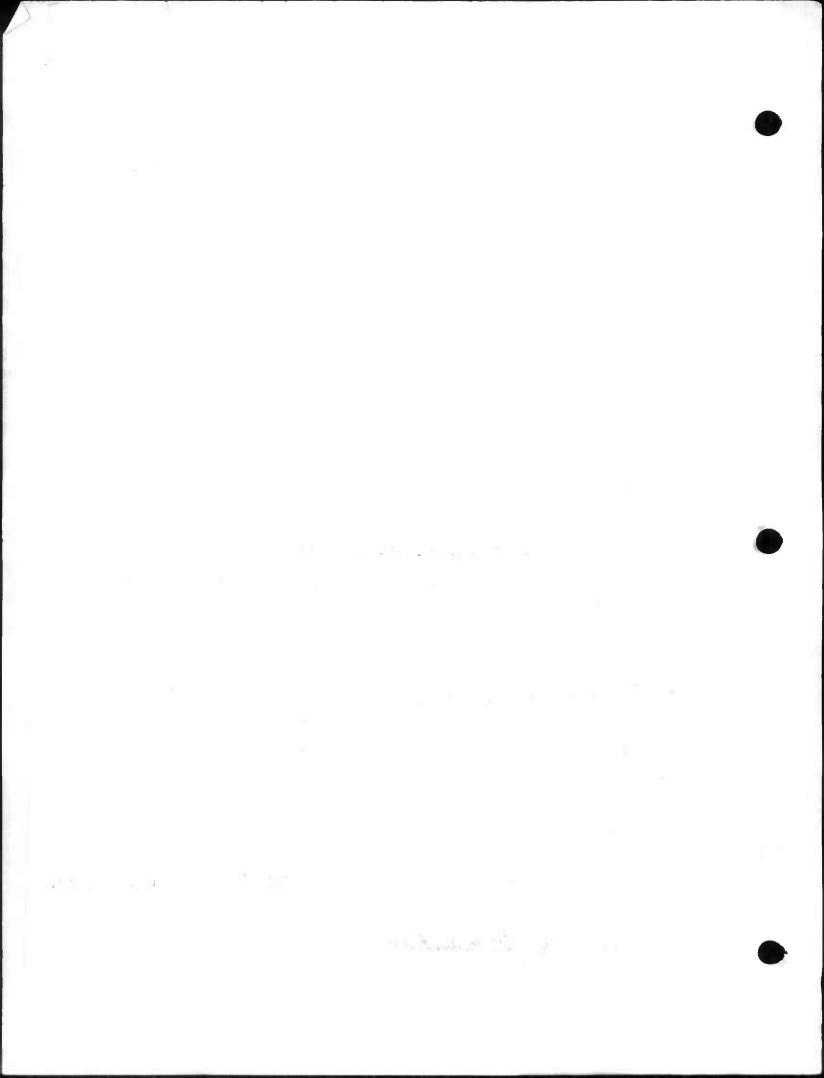
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DAVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

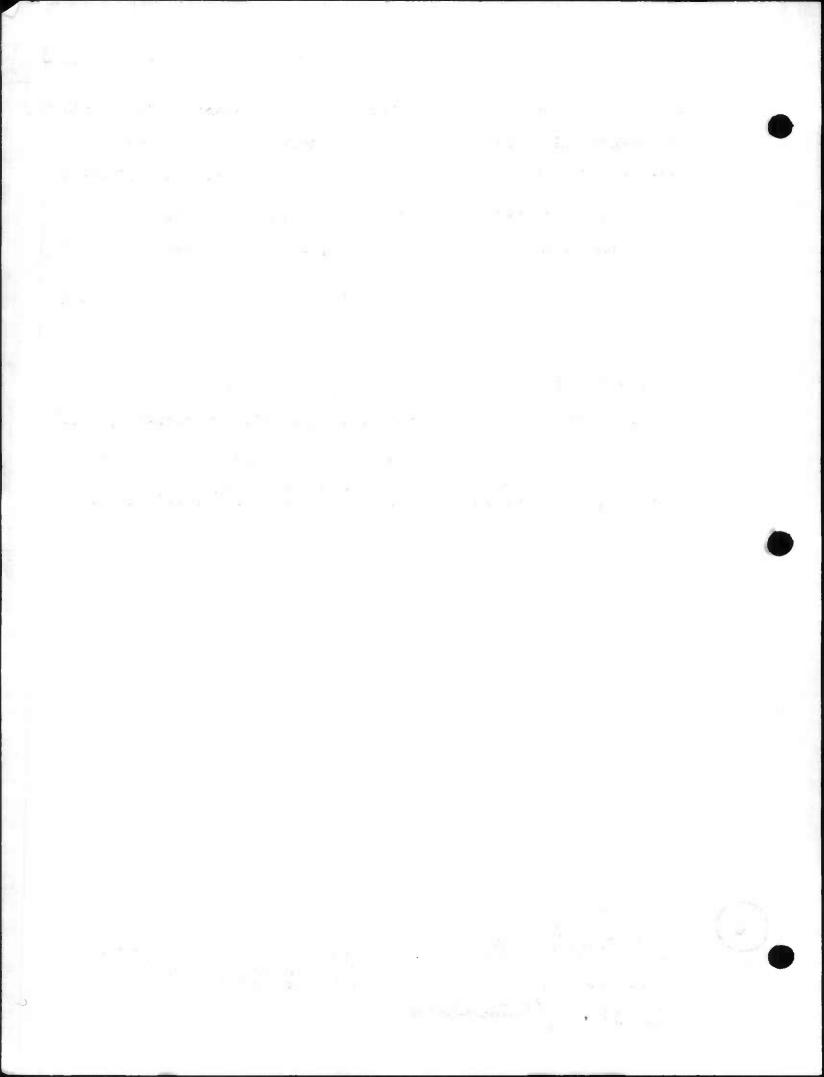
| | | | | | | IONI | | DEA | | HEG. NO. | | | | | |
|---|--|-----------------------------|------------------------------|----------------------------|--|---|---|---------------|----------------|--|-------------------|------------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, | | | | | | | | | 2. DATE OF DEATH DA | | YEAR | . TIME OF DEATH | | |
| | NORWOOD | | | | | | | | | Feb. 8 | 1 | .996 | 9:51 p ^w | | |
| | 4. SOCIAL SECURITY NUMB | | 5. SEX | 6. AGE (In yrs. Is | | IF UNDE | DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPL Country) | ACE (State or Foreign | | |
| l | 213-30-4552 | | 1 X M 2 - F | 61 | YRS. | | | | .55.51 | Jan. 3,1 | 935 | North | h Carolina | | |
| _ | 9e. FACILITY NAME (If not in | | | | | | | | ON OF DEA | ATH | 9c. COU | INTY OF DEA | ТН | | |
| <u> </u> | | ainor A | Ave. | | | Ba | ltin | юrе | | | | N/A | | | |
| <u>.</u> | RESIDENCE OF DEC | 10b. COUNTY | - | | T the CIT | y mww | OR LOCA | TION | | | | | Od. INSIDE CITY | | |
| DIRECTOR | Maryland | N/ | 'A | | | | more | | | | | | LIMITS? X YES 2 NO | | |
| 4 | 100. STREET AND NUMBER | | | | | | 10 | . ZIP COD | _ | | 10g. CIT | IZEN OF WH | AT COUNTRY? | | |
| FUNERAL | 3502 T | rainor' | Ave. | | | | | 2121 | 15 | | Ţ | J.S.A. | | | |
| | 11. MARITAL STATUS | | 12. WAS DECEDEN FORCES? 1 | | | 13. | WAS DEC | ENDENT C | OF HISPANI | C ORIGIN? (Specify Yea , Puerto Ricen, etc.) | or No — | 14. RACE - | - American Indian, White, etc. | | |
| BY | 1 Never Merried 2 3 Widowed 4 Divo | | IF YES, GIVE W | | | | | 2XXNO | | | | Specify: | White | | |
| 9 | | EDENT'S EDUC | | | ECEDENT'S | | | | | 16b. KIND OF BUS | SINESS/INI | DUSTRY | | | |
| | Elementary/Secondary (0 | ly highest grade (0-12) | College (1-4 or 5 | lié. | Give kind of e. Do NOT u | work done se retired.) | during mo | st of working | ng | | | | | | |
| 릴 | 9 | | | | 1umb | er | | | | Se | Self-Employed | | | | |
| COMPLET | 17. FATHER'S NAME (First, M | fiddle, Last) | | | | | | 18. MOT | HER'S NAM | E (First, Middle, Maiden | o, Maiden Sumame) | | | | |
| BE | 0dious | | Andrews | | | | | | Lec | ola | Sellers | | | | |
| 0 | 190. INFORMANT'S NAME (7 | Type/Print) | | 19 | b. MAILING | ADDRES | S (Street | and Number | r or Rural Ro | oute Number, City or Tow | n, State, Zij | | | | |
| ĭ | Mrs. Patsy | | dt | | 101 Springrove Ave. Dayton, Ohio 45409 | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITE 1 X Burlet 2 Cremetio 4 Donation 8 Other | on 3 🗆 Remo | oval from State | 20b. PLACE cemetery, cr | and date | DATE OF DISPOSITION / Name of DATE 20c. LOCATION — City or Town, State 2/12/96 Baltimore, Md. | | | | | | | | | |
| İ | 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | | | | | | | | | | | | |
| | ▶ Roberi | tm | Kra | 2 | | | Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212 | | | | | | | | |
| | 23. PART i. Enter the di | isesses, or c | omplications the | and the d | eath. Do | not ente | r the mo | de of dy | ing, auch | aa cardiec or reapi | retory ar | rest, | Approximate | | |
| | IMMEDIATE CAUSE (Fin | | ,, | an outil in | | | | | | | | | Interval Between Onset and Death | | |
| | disesse or condition | → , | MYOC DUE TO | ARDIAL | - 11 | FAR | CTI | DD | | | | | | | |
| | | | | | | | | | | | | | | | |
| ξ | Sequentially list conditi | lone b | AKTEM | LWSCL | ENO | TIC | CAR | DID | MASC | ULAR PI | SEA | 50 | | | |
| HILICALION | if any, leading to immed | diate | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| 3 | cause. Enter UNDERLY! CAUSE (Disease or inju | | DUE TO | (00 40 4 00) | OUTWAR O | | | | | | | | | | |
| 1 | that initiated events resulting in death) LAS | т | DOE 10 | (OR AS A CONSE | OUENCE O | r): | | | | | | | | | |
| ן ה | | 0 | l | | | | | | | | | | | | |
| | PART ii. Other significe | ent conditions | contributing to | death but not | reaulting | in the u | nderlyin | g cause (| given in F | Pert I. 24s. WAS AN | | | ERE AUTOPSY FINDINGS | | |
| DICAL | COPD | | | | | | | | | PERFOR | - | C | WAILABLE PRIOR TO OMPLETION OF CAUSE | | |
| 4 | CHNOME P | ANCRU | EATIL 11 | JSUFFI | CIE | UUS | | | | _ ' ' ' ' | A no | | F DEATH? | | |
| - | DID TOBACCO | O USE C | ONTRIBUTE | TO CAU | SE OF | DEA | TH Y | ES X | NO | | | | _ ,23 2 _ 10 | | |
| 4 | 25. WAS CASE REFERRED TO | O MEDICAL | | | | | 26. P | ACE OF D | EATH (Chec | ck only one) | | | | | |
| 2 | EXAMINER? | | HOSPITAL: | ER/Outpetlent | 3 DOA | OTHE | R: | 1 | | Other (Specify) | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | 28b. TIM | E OF | 28c. IN. | URY AT | | 28d. DESCRIBE HOW II | NJURY OC | CURED | | | |
| - 10 | | Pending Investigation | (Month, D | ay, 19ar) | IN. | JURY M | | YES 2 | NO | | | | | | |
| 2 Accident average and Number of Burney and Number | | | | | | | | | r or Rural Rou | ite Number, | | | | | |
| 4 Homicide determined | | | | | | | | | | | | | | | |
| ۱ ۲ | 290. CERTIFIER 1 XCERT | TIFYING PHYSIC | CIAN: To the heat of | mu knowledge d | anth again | and and the | None deta | | | o the cause(e) end mar | | | | | |
| OMPLE | | | | | | | | | | io the cause(e) end mar ime, date end place, en | | | ad manage on stated | | |
| 3 | 29b. SIGNATURE AND TITLE | | | | | | | | | | | | | | |
| H H | A sassada. | 1/ | MANN | 10 | | | | | SI35 | | | | Ionth, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF | F PERSON WAL | COMPLETED CALL | SE OF DEATH AT | EM 27 /5 | Onine) | <u> </u> | 41- | 105 | | - | En. | 1,1996 | | |
| | Penelope | P. Sco | | | | | Balt | imore | e,Mar | yland 212 | 31 | | | | |
| | 31. DATE FILED (Month, Day. | | 32. REGISTRA | R'S SIGNATURE | 0 | | | | | | | | | | |
| M | FEB: | 1 3 199 | 6 Jalia | Mudden | adell | | | | | | | | | | |



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State of Maryland / Department of Health and Mental Hygien Q C 02500

| | | | | | | 10.710.10 | Cer | tificate of | Death | | Reg. Nu | U | 3309 | |
|------------|--|-------------------|--|--|--|---|--|---|--|---|------------------------------------|---|---|--|
| | Dhuala | | 1. Decedent's Nam | ne (First, Middle, La | ist) | | | | | 2. Date of Dea | ath | Yesr | 3. Time of Death | |
| | Physic /Medi | | John | Linwo | od | | As | kew | | February | 3, 1996 | 1881 | 4:10 A.M. | |
|): | Exami | | 4a. Facliity Name (| If not institution, giv | re street end numbe | r) | | | 4b. City, Town, or I | ocation of Death | 4c. County | of Death | | |
| | | | Physicians | s Memorial | Hospital | | | | La Plata | | Charl | es | | |
| | Funeral Director | | 5. Sociel Security N 214-52-8 Usual Residence of | 3907 | Sex 7. / 1 SgM 2□ F | 46 | st birthday) Yrs. | If Under 1 Year Months Days | Hours Min. | 8. Deta of Birth (Month, Day Apr. 6 | , Year) , 1949 | 9. Birthp Cour Virg | place (State or Foreign ntry) Jinia | |
| | land m | | 10a. State | 10b. County | | 10c. City, | Town or Lo | cation | | | | 1 | 10d. Inside City Limits | |
| | he Marylar 28a-f show cutted at | ector | MD | Anne Ai | rundel | 4820 | Rive | | drive, | | | | 1 XYes 2 □ No | |
| | ath with t | Funeral Director | | verside | | | | 10f. Zip Code 207 | | 1 | 10g. Citizan of V USA | | | |
| 21215-0020 | be filed within 72 hours after death with the Maryland hat Hygiene. d other than "natural", or flems 23a or 28a-f show event, the Modical Exerting must be notified at | þ | 11. Marital Status 1 Never Mari | led 2 Merried 4 Divorced | 12. Was Deceder Armed Forces 11 Yes 2 If Yes, Give Yeer or Dates | ?] No | | Ves Decedent of I Yes, specify Cub | dispanto Origin? (Si en, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | Specify | ck, White, | can Indian, etc. Thite | |
| 5-0 | 72 h | etec | (Spe | 15. Decedent's E | ducation ade completed) | | 18a. Deced | ent's Usual Occup | pation during most of world) | kina | 18b. Kind of B | usiness/In- | dustry | |
| 121 | hen vithin | Completed | Elementery/Seco | | College (1-4o | r 5+) | | OONOT use retire | | | Pape | r | | |
| | filed with Hygiene. Ither ther | | 12 | (First, Middle, Last | <u> </u> | | r upc. | Cutti | | na (Eirat Middle | | | | |
| Maryland | A E P | Be c | | L. Aske | • | | | 100 | 18. Mother's Name (First, Middle, Maiden Surname) Ruby Burton | | | | | |
| 7 | 2 should and Mer is marke aumatic | 2 | | ame/Relationship (| | | 19b Mallin | n Address (Street | | | r, City or Town, State, Zip Code) | | Code) | |
| | 1 and 2 : Health ar em 27 ls other trau | | | 1. Turne | | | | | | | | or Town, State, Zip Code) ville, MD 207(| | |
| J.e. | of Her of Her I Item | | 20a. Method of Dis | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or | | | | | | | own, Stete | |
| E | Pages nent of int: If its iry or o | | | | | | | cyland Veterans Cem.2/6 Crownsville, N | | | | | | |
| Baltimore, | permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marks any Injury or other traumatic ODCe. | | 21. Signature of Fi | inemi Service Lice | neee O | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. | | | | | | | |
| Ш | 80559 | | 2011 | V. V.S | 2.16MH | 2 | H 6 | raesty | Tunera | T HOME | , P.A. | D 3 | 1401 | |
| | | | 23s. Part1. Enter I shock, or hea | he disease, or com int feilure. List only | plications that cause on each | ed the deeth. line. | Do not ente | or the mode of dyl | ng, such es cardiac | or respiratory ar | reat, | | Approximate Interval Between Onset and Death | |
| | Physician /Medical | | | | 1 -1. | | land | in 1 | redicion | rila. | Mara. | 0 | Onset and Death | |
| | Examiner | | Immediate Cause disease or condition resulting in death) | n Irinei | a. 41140 | wx | cleratic Cardiovascular Disease via | | | | | | | |
| | | ē | | | | Due to (or as a consequence of): | | | | | | | / | |
| | tificate be executed ig physician and as the burial-transit | Examiner | Sequentially list co | enditions, | b | Due to (or a | as a conseq | uence of): | | | | | | |
| 68760, | be estician buria | | Sequentielly list co if any, leading to in ceuse. Enter Unde Cause (Disease or that initiated events | erlying injury | C | | | | | | | | | |
| 687 | ficate p phys | Physician/Medical | resulting in death) | Lest | | Due to (or e | s e consequ | uence of): | | | | i | | |
| Вох | attending for use a | M | | | d | | | | | - 51 | | | | |
| | The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a | slcia | Pert II. Other signif | icant conditions of | ontributing to death | but not result | ing in the un | iderlying cause gi | ven in Part I. | 23b. Did t | obacco use co | ntribute to | o the cause of death? | |
| P.0 | by th | hys | | | | | | , | | | res 2 No | 3 Pro | | |
| | es that igned I be det | by | | | | | | | | | | | | |
| Records, | v requin | Completed | | | | | | | | 24a. Was perfo | an autopsy med? | av | ere autopsy findings reliable prior to empletion of cause | |
| 3ec | has b | nple | | | | | | | | | | of | death? | |
| a F | | | | | | | | | | 1 🗆 Y | es 20 No | 1[| ☐ Yes 2☐ No | |
| Vital | Physician: The this certificate ral director, par | Be | 25. Was case refer examiner? | | Hospital: | | / | Ott | har: | th (Check only o | | | | |
| of | this ral di | - To | 1 DYes 2 □ 27. Manurer of Deat | | 1 ☐ Inpa | | R/Outpatient 8b. Time of | 3LI DON | 4 LI Nursing n | ome 5 Resid | | | (V | |
| O | ding it. After funer | tion | 1 Natural | 5 Pending investigation | (Month, D | ay Year) | Injury | 28c. Inju Wo | rk? Yes 2□No | 200. 20001201 | ow injury occur | 60 | | |
| Division | or Attending after death. Director: After In by the fune | Certification: | 3 Sulcide | 6 Could not b | e 28e. Place of I | njury - At hom | e, farm, stre | et, factory, office | | | | er or Run | al Route Number. | |
| ă | after Direct d in by | Sert | 4 Homicide | | building, e | etc. (Specify) | | | | City or Tow | n, State) | | | |
| , | P. P | Medical (| 29a. Certifier (Check only | 1 Certifying Ph 2 Medical Exam | ysician: To the bes | of examinatio | edge, death n and/or inv | occurred at the tile estigation, in my o | me, date end piece opinion, death occu | , end due to the c rred et the time, c | cause(s) and ma date end plece, | nner as s | tated. the cause(s) | |
| (| Man du | Me | 29b. Signature and | Aprilipento elle | and monders | week. | | 29c. Licens | se number | | 29d. Date signe | Mayth. | Day, Year) | |
| ' | | | V/A | Month | un Mi | 1. A. A. | noha l | NE D-464 | 10 | | 21 | 3/91 | | |
| | 7 | | 30. Nerve and addr | ess of person who | completed cause of | death (Item 2 | 3a) (Type, 1 | | d Line Cent | er. Suite | 100 | 114 | | |
| | | | | etchford, | | | | | f, Maryland | 20602 | | | | |
| | Sta | _ | 31. Date flied (Mon | th, Day, Year) | 2. 32 Regis | trar's Signatu | ra - | | | | | | | |
| | Registr | ar | FEB 1 3 | 1996 | 7 una vallaso | An-Marian | 1000 | | | | | | | |

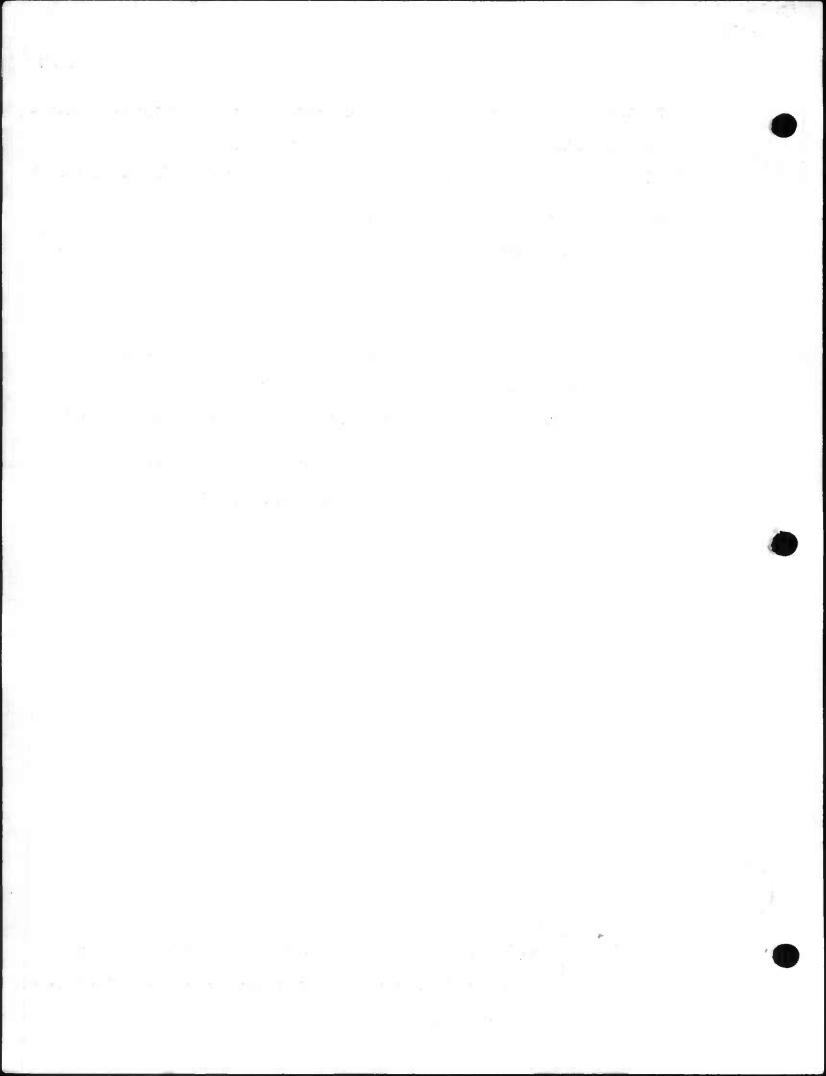


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State of Maryland / Department of Health and Mental Hygiene 96

| | | | | | | Cei | rtificat | e of | Death | | R | eg. No. | | | |
|------------|---|--|--|---|--------------------------------|------------------|-----------------------------|------------|---|-----------------------|--|---------------------------------------|-------------------------------------|---|-----------------------------|
| | - | | Decedent's Neme (First, Middle, La | ist) | | | | | | | 2. Dete of Dea | th | Maria | 3. Tim | a of Deeth |
| | Physic /Medi | | PRESTON | ELVONDO | | | I | BARN | NES | | Month FEBRUA | RY 7. | Year 1996 | 8:4 | 4P.M. |
|) | Exami | | 4a. Facility Name (If not Institution, give | re street and numbar |) | | | 1 | | wn, or Lo | ocation of Death | 4c. County | of Death | | 7.2 0.1.0 |
| | ret i | | 2600 BLK.KIRK | | | | | | BALI | | | | n/a | | |
| | Funeral Director | | 5. Sociel Security Number 219-86-0567 Usuel Residence of Decedent | Sex 7. A | ge (In yrs. last b | irthday) Yrs. | If Under Months | Days | If Under Hours | Min. | 8. Date of Birth Month, Day MAR • II | Year) 73 | 9. Birthp BALT | leca (Ste 11MOR | te or Foreign E, MD |
| | h the Maryland r 28a-f show | tor | 10a. Stete 10b. County MD n/a | l | 10c. City, To | | cation TIMOF | RE | | | | | 1 | | e City Limits |
| | ath with the 23e or 28e | il Director | 10e. Street and Number 3318 CARDENAS | AVENUE | | | 10f. Zip | Code | 21 | 213 | 1 | Og. Citizen of UNITED | | try? ATES | 5 |
| 020 | ours after dearal, or items | by Funeral | 11. Meritel Status XXX Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forcas 1 ☐ Yes XIX If Yes, Give Yaer or Detes: | ? | 1 | Wes Daced If Yes, spec | cify Cube | lispanic Ori en, Mexican Specify: | gin? (Sp n, Puerto | ecify Yes or No- Rican, etc.) | | ce - Americ ck, White, v: BL/ | etc. | ١, |
| 5-0 | hin 72 ho | eted | 15. Decedent's E (Specify only highest gro | ducation ade completed) | 166 | . Deced | dent's Usue | el Occup | etion during mos | t of work | ina | 16b. Kind of B | usinass/Ind | dustry | |
| 21215-0020 | d withir giene. r than | Completed | Elementery/Secondery (0-12) 11 th | College (1-4or | 5+) | life. L | orer | se retired | d) | . 0, 110111 | | vari | ous | trad | des |
| pu | 0 - 0 - | Be C | 17. Father's Neme (First, Middle, Last |) | | | | | | | e (First, Middle, | | ne) | | |
| <u>Ial</u> | | ToE | PRESTON BARNE | ES JR. | | | | | S | YLVI | A THO | MAS | | | |
| , Maryland | nd 2 shoulth end 27 is m | ľ | 19e. Informent's Neme/Raletionship (| | 19 | b. Meilin | Address | AR DE | en <i>d</i> Numbe | AVEN | al Route Number | TIMORE, | Stete, Zip | 2121 | 3 |
| Baltimore, | Pages 1 end nent of Healt ant: If Item 27 ury or other | | 20e. Method of Disposition 1 ☑ Suriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Special | | 20b. Plece cemate K I NG | ary, cren | sition (Name matory or o | ther plea | PARK | 2- | Dete -14 | 20c. Location | City or To | | |
| Balt | permit. Pages Department of Important: If it any injury or once. | | 21. Signeture of Funerel Sarvice Lice | Ren | | - | | | ss of Facilit | | 1101 E. | NORTH | AVE | NUE | |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disesse, or com shock, or heert feilure. List only Immediate Cause (Finel disesse or condition resulting in deeth) | one ceuse on each | d the deeth. Doine. | zuuz | 0 | | yes | cardiac | or respiretory em | ast, | | | mata Between nd Deeth |
| ox 68760, | death certificate be asscuted a sitending physician and d for use as the burial-transit | n/Medicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury that Initiated events resulting in deeth) Last | bd | Due to (or es e | | | | | | | | | | |
| O. | the death y the atter | Physiciar | Part II. Other eignificant conditions of | ontributing to death I | out not resulting | in the ur | nderlying c | ause giv | en in Pert I | * | 23b. Did to | bacco uee co | ntributa to | the cau | ea of death? |
| S, P. | that led to det | by Ph | | | | | _ | | - | | 1 □ Y | es 2 No | 3 ☐ Prot | oably 4 | Unknown |
| ecord | aw requir ss been s 2 should | Completed b | | | | | | | | | 24a. Was e perfor | n eutopsy med? | CO | are autopalleble pr mpletion death? | |
| = E | The ate h | Con | | | | | | | | | 1000 | es 2 No | 1 [| Yes : | 2 No |
| Vital | ysicien: The | Be | 25. Wes case referred to medical exeminer? | 112 | | | | | 26. Plece | of Deet | h (Check only or | ie) | | | |
| o | Physician: this cartific ral director, | T ₀ | XXYes 2□ No | Hospitel: 1 Inpati | | | | | 4 LI NU | | me 5 Resid | | er (Specif) | ON | STREE |
| Division | or the nding the sath. Innetor: After in by the fune | 27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide 4 Homicide 2 Roole of Injury (Month, Dey Year) 2 R | | | | | | | | No | 28d. Describe he SUBJEC 28f. Location (S City or Town | T SHOT treet end Numb n, Stete) | - | / Routa / | (Mount |
| 1 | Hospita 24 hospita Funeral riely filled | edical Ce | | ysician: To the best | exemination e | | | | | d plece, | | euse(s) end m | | | I IMORES |
| | within a To the comple | Med | 29b. Signatura and little of certifies | and meaning at | nted. | | | . Licens | e number | | 2 | 9d. Date algne | d (Month, | Day, Yea | r) |
| | Sta | te | 30. Name and eddress of person who MARIO F. GOLD 31. Dete filed (Month, Day, Year) | E JR 1 | | | | n St | reet | ., В | altimo | re, Ma | aryla | and | 21201 |

FEB 1 3 1996 Shi De Barker Roll



Item2 2-13-96 FilmG732 W/H Per F/H

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| | | | | | | Ce | ertificate o | f Death | R | eg. No. | 0 | 03211 |
|-------------------|---|------------|---|---|---|-------------------|--------------------------|--|--|---------------------------------------|-------------------|---|
| т | 5 1 | | 1. Decedant's Name (First, Middla, La | st) | V | | | | 2. Dete of Deat Month | | Year | 3. Tima of Death |
| | Physici /Media | | | Robe | ert (| С. | Burns, | Sr. | Feb.9, | | | 1:30 PM |
| | Examir | | 4a. Facility Nama (If not institution, giv | e street and number) | | | | 4b. City, Town, or | Location of Death | 4c. County | of Deeth | |
| | | | 1562 Long Poi | | | | | Pasade | | | | nde1 |
| ı | Funeral Director | | 236-12-7934 | ex 7. Ag | a (In yrs. last 81 | birthday Yrs. | Months Day | | | Year) 191 | 9. Birthi Coul | place (State or Foraign mtry) W, Va. |
| | pue * | | Usual Residence of Decedant 10a. Stata 10b. County | | 10c. City, T | own or L | ocation | | | | Τ. | 10d. Inside City Limits |
| | Menyl f sho | ō | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | 1 ☐ Yes 2 MNo |
| | the 1 | Director | Md. Anne Ar | under | | Po | asadena 10f. Zip Code | | 1 | Og. Citizen of V | What Cou | ntry? |
| | death with the Meryland ms 23s or 28s-f show f must be notified at | | 1562 Long Poir | t Road | | | | 1122 | | U.S. | | , |
| | me 2 | Funeral | 11. Maritai Status | 12. Was Decedent Armed Forcas? | Ever in U,S. | 13. | | f Hispenic Origin? (Suban, Maxican, Puer | specify Yes or No- | 14. Rac | e - Amari | can Indian, |
| 21215-0020 | or its | by | 1 Never Merried 2 Married 3 Widowed 4 Divorced | Armed Forcas? 1 ☐ Yes 2 ☐ If Yas, Giva Yaar or Datas: | | | 1 ☐ Yas 2 ☐ N | | to Rican, atc.) | Specify | ck, Whita, | anc. White |
| 5-0 | 72 hours | Completed | 15. Decedant's Ed (Specify only highest gra | | 1 | 6a. Dec | edant's Usual Occ | cupation | deina | 16b. Kind of B | ısinass/in | dustry |
| 121 | ighin and | nple | Eiamantary/Secondery (0-12) | Coilaga (1-4or 5 | +) | | | na during most of wo | in ig | | | |
| | filed within Hygiene. other than | ပိ | 12 | | | Cor | nductor | | | B.&O. | | 1road |
| anc | Mental F Mental F arked off attc ever | Be | 17. Fethar's Nema (First, Middla, Last) | | | | | 18. Mothars Na | ma <i>(First, Middl</i> a, <i>l</i> Cora Wa | | 10) | |
| 2 | should be filed and Mental Hygi marked other umatic event, in | 70 | Ralph Burn 19a. Informant's Name/Ralationship (| | | 10b Mai | line Address (Ctro | et end Number or Ri | | | Ctata 7is | Code) |
| Maryland | 2 9 9 9 | | | | | | | | | | | |
| re, | ages 1 and nt of Health if Item 27 or other tr | | Robert c. Burn 20a. Mathod of Disposition | IS, UR. | 20b. Piace | e of Disp | osition (Nema of | n Ct. Pa | | 20c. Location - | | |
| altimore, | | | 1 ☐ Burial 2 ☑ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specif | | | | amatory or other p | ry, Inc. 2 | /12/96 | Caton | svi 1 | 1e. Md. |
| | | | 21. Signature of Funerel Sarvice Licer | · | / | | 22. Nama and Ade | | ,, 12,39 | cabon | 011 | ite, Ha. |
| ä | Departr Departr Imports any Inje | |) Eugens | Carto | 1 | | | y Funera | | | | |
| | _ | | 23e. Pert1. Entar ha disaase, or com shock, or heert failura. List only | pilcations thet caused | tha daath. [| Do not a | 3204 M | ountain lylng, such es cardla | Road Pa | asaden est. | a,_N | 1d. 21122 Approximata |
| | Physician | | shock, or heert failura. List/only | ona causa on each lir | 10. | | | | | | | Intarval Between Onset and Death |
| 7 | /Medical | | Immediate Causa (Final disease or condition | Po | 2004 | 01 | · NO. 5 | 20,00 | 0 | | İ | 72 |
| н | Examiner | | rasulting in daath) | a | Due to (or as | a conse | equence of): | Harry C | 1 | | | ray |
| | 70 25 | ner | | . Chro | nu | B | rench | to AN | N | | | Bouins |
| | rificete be executed ng physician and es the burial-transit | Examiner | Sequentielly list conditions, | b | Due to (or as | a conse | aquance of): | | | · · · · · · · · · · · · · · · · · · · | | 20-1112 |
| 60, | cian s | <u>E</u> | Sequenticity list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disease or injury | c | EN | M | Urser | ver. | | | | |
| 68760, | physi the | edicai | that initiated evants resulting in death) Last | D . | Dua to (or as | a conse | equence of): | (| | - | | |
| | | 2 | L | a Type | tin | Y | agar | utte 3 | mohu | ng | - | |
| Box | leath certifice attending ph d for use es th | clar | | U | ' | | 0 | | 1 | 0 | i | |
| P. 0. | the d | Physician/ | Pert II. Other significant conditions of | ontributing to death be | ıt not rasultin | ig in tha | undarlying causa | given in Part I. | 1 | | | o the cause of death? |
| | that hed b | by PI | | | | | | | 100Y | ee 2□ No | 3 Pro | bebly 4 Unknown |
| Records, | law requires that the death ce es been signed by the attendi s 2 should be detached for use | | | | | | | | 24e. Wes e | n autopsy | 24b. W | are autopsy findings |
| 00 | w rec | lete | | | | | | | perform | med? | CC | rallable prior to empletion of causa death? |
| | The lav ate hes page 2 | Completed | | | | | | | 1 🗆 Y | es al No | | Yas 2 No |
| ta | | 0 | 25. Wes casa rafarred to medicai | | | | | 26. Place of De | ath (Check only on | | 1 | 272110 |
| > | Physician: rthis certific rral director, | ToB | axaminer? 1 ☐ Yas 2 No | Hospital: | nt 2 ER | /Outpatle | ent 3 DOA | Othar: 4 Nursing H | | ence 6 Oth | er (Speci | (v) |
| 0 | After thi funeral | | 27. Menner of Death ☑ Naturel 5 ☐ Panding | 28a. Data of Inju | y Year) 28 | b. Tima Injury | of 28c. In | | 28d. Dascribe ho | | | |
| 0 | 1122 | cation | 2 Accidant investigation | 1 | | 111/417 | | ☐ Yes 2☐ No | | | | |
| Division of Vital | 200 | Certific | 3 Suicide 6 Could not be determined | 28a. Place of Inju- building, ato | ury - At homa c. (Specify) | , farm, s | straet, factory, offic | >e | 28f. Location (St City or Town | treet and Numb n, Stete) | er or Run | al Routa Number, |
| | To the Hospital within 24 hour To the Funer completely files | | 29a. Coulifier 1 Certifying Ph | ysician: To the best of | f my knowlad | dga, daa | th occurred at the | time, dete and place | e, end dua to tha ca | ausa(s) and ma | nnar as s | stated. |
| | To the Hosp within 24 hou To the Fune completely fil | edical | (Chack only Art Bedicel Exam | ninar: On the basis of end manner sta | axamination ted. | end/or li | nvastigation, in m | y opinion, deeth occu | urred et the tima, d | ate and place, | and due t | o the ceuse(s) |
| | Tot Tot | Σ | 29b. Signature and little of certifier |) | | | 29c. Lice | ensa number | 2 | 9d. Deta signe | d (Month, | Day, Year) |
| | | | Me | l- | | | D | 13343 | | 2/10 | 116 | |
| | | | 30. Nama and address of person who | complated causa of d | aath (item 23 | a) (Type | Print) | - Hosp | 1 1 - | 1 | 300 | 1 S. Hanove |
| | | | Calvin Fun | marin | M.M | D. | Harbo | - Hosp | ital Ce | enter | 21 | 125 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 1 3 199 | 6 Jun a | r's Signatura | Park | 45 | | | | | |

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| 11-00 | | | | | · y raina r | Certific | | | F | Reg. No. | | | |
|---------------------|---|----------------|--|--|---|--|--------------------------------|---|---------------------------------------|------------------------------------|------------------------------------|--|---------------|
| | Physic | an | 1. Decedant's Nama (First, Middle, Last) Mary C. Ballard | | | | | | 2. Data of Dea Month | Day | Yaar | | of Death |
| Л | /Medi | | 4a. Facility Nama (If not institution, giva | | . В | ıııaıu | | 4h Cihi Toum or | Feb. 8 | ,1996 | -4 D45 | 11: | 00 A. |
| 1 | Examir | ner | 1422 Light | | | | | | City, Mc | | one | | |
| Н | Funeral | | 5. Social Security Number 6. Sec | | (In yrs. last b | | nder 1 Yaar | | 8. Data of Birt | | | laca (Stata | a or Foraign |
| si | Director | | 214-20-5098 1C | ¹ M 2√F 6 | 8 | Yrs. Mon | ths Days | Hours Min | Feb. 16 | , 1927 | Mar | ylan | |
| | ryland how | | 10a. Stata 10b. County | | 10c. City, To | wn or Location | | | | | 1 | 0d. Insida | City Limits |
| | e Ma | cto | Maryland non | e | Ba1t | co.Cit | y,Md | • | | | | 1 X Ye | s 2 No |
| | 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | Director | 10e. Street and Number | | | 10f | . Zip Coda | | | 10g. Citizan of \ | What Coun | try? | |
| | 23 | erai | 1422 Li | | | 140 141 - 5 | | 1230 | | nited | | | |
| 020 | hours effer death with the Maryland hurst, or flems 23a or 28a-f show at Examiner must be notified at | by Funeral | 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ev Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: | | | specify Cub | en, Maxican, Pual Specify: | Spacify Yas or No- to Rican, atc.) | | e - Amaric ck, Whita, WWhita | atc. | |
| Maryland 21215-0020 | n 72 | Completed | 15. Decedant's Edu (Specify only highast gradi Elamentary/Secondary (0-12) | cation a completed) Collega (1-4or 5+) | | a. Decedant's I (Giva kind o lifa. DO NO | work dona | during most of wa | orking | 16b. Kind of B | usinass/Ind | dustry | |
| 121 | e filed with! al Hygiene. other than vent, the M | | 12th.Grade | none | | Secre | tary | | | Md.Lumbe | | | |
| anc | 0 % D . | Be | 17. Fafhar's Nama (First, Middla, Last) | | | | | | ma (First, Middla, | | | | |
| Ž | should be and Mentel amarked of urmatic eve | 2 | Louis Gi 19a. Informant's Name/Ralationship (Ty | otis_ | | No. 8 de lliene Auto | (Ot | | aret | | Kloid or Town, Stata, Zip Coda) | | |
| | C1 m 72 8 | | Mr.John Hoover | pa, runij | 14 | | | | alto.Mc | | | Coda) | |
| re, | f Heelth Item 27 other tr | | 20a. Mathod of Disposition | | 20b. Piaca | of Disposition | (Nama of | | Data Data | 20c. Location | | wn, Stata | |
| E | Pages nent of mt: If its iry or o | | 1 ☑ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Othar (Specify) | | | | | etery 2 | /10/06 | A.A.(| O M | 4 | |
| Baltimore, | 교 된 큰 큰 . | | 21. Signature of Funaral Sarvice Licanse | 100 | / | 22. Nam | a and Addra | ss of Facility | | | | | |
| œ | Depa impo any is | | Balto.Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | | | | | | | | |
| | Physician | | 23e. Pert1. Enter the diseese, or complishock, or heart failura. List only or | | / | not antar tha | moda of dyli | ng, such as cardia | c or raspiratory ar | rest, | | Approxim Interval B Onset and | ata etween |
| | /Medical Examiner | L | Immediata Causa (Final disaasa or condition rasulting in daath) | Aci, | ue to (or as | Typ Ca | india ot): | 1- po | udin | | | | |
| | outed nd nansit | Examiner | Sequentially list conditions | 9 111 | | a consequence | | ndio 0 | usuda | n dis | 164 | | |
| Ő, | ificate be executed g physicien end as the burlet-transit | | | | | | | | | | | | |
| 68760, | cata b | edical | that initiated evants resulting in death) Last Dua to (or as a consequence of): | | | | | | | | | | |
| _ | E 0 0 | | | | | | | | | | | | |
| Вох | that the death cert ed by the attendin detached for use | Physician/M | | | | | | | | | | | |
| P.O. | the d ny the | hysi | Part II. Other significant conditions con | tributing to death but | not rasulting | in the underlyi | ng causa gh | van in Part I. | | obacco use co | | | |
| | requires that the death cer seen signed by the attendin should be detached for use | by PI | | | | | | | 10. | res 2□ No | 3 Prot | bedry 4 | Unknown |
| Vital Records, | 2 8 8 | Completed | | | | | - , . | | 24a. Was perfo | an autopsy med? | ave | ara autopsy aliabla prio mpletion of death? | r to |
| <u>~</u> | Pa es | Соп | | | | | | | 1 D Y | as 2000 | 10 | Yas 2 | No |
| Vita | rsician: The s certificeta director, pag | Be | 25. Was casa rafarred to medical axaminar? | a a a la a la | | | Tai | | ath (Check only o | ne) | | - | |
| 0 | lis o | To | TEXTES ZU NO | ospital: | 1 | | DOA | | Homa 5 Rasio | | | r) | - |
| | 2 4 | tion | 27. Mannar of Death 1 S Natural 5 Panding invastigation | 28a. Data of Injury (Month, Day | | Tima of Injury | 28c. Inju | ryaf rk? Yas 2 □ No | 28d. Dascribe h | ow Injury occur | red | | |
| Division | or Attendation after delibertor | Certification: | 2 Accidant invastigation 3 Sulcida 6 Could not be datarmined | 28f. Location (S City or Ton | 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) | | | | | | | | |
| | To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by II | edicai C | 29a. Certifiar 1 Certifying Phys (Check only one) | ician: To the best of lear: On the basis of a and manner state | xamination a | ga, daath occur nd/or invastiga | red at tha ti tion, in my o | ma, data and plac opinion, daath occ | e, and dua to tha ourred at tha tima, | causa(s) and mi data and place, | annar as st and dua lo | ated. tha cause |)(s) |
| | To the To the Comp | ž | 29b. Signatura and titla of cartifiar | 10 | , . | | 29c. Licans | sa number | | 29d. Date signe | d (Month, | Day, Year) | |
| | | | Micardo | Joja La | MD | | Dog | 220 | | 2/9/9 | 36 | | |
| | 4 | | 30. Nama and addrass of person who co | mplated causa of das | | (Type, Print) | a.TI | Char | les St. 65 | alfr. M | (8 21 | 230 |) |
| | Sta | te | 31. Data filed (Month, Day, Year) | a Day (A) | - | | | | | - | | | |
| | Registr | 24 | LERT 9 TUYL 5" | - TOTAL LONG | 1 | | | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene 03513 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month KATHERINE F. BENDER FEBRUARY 9, 1996 5:30 PM /Medical 4e. Fscility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1 WEST CONWAY STREET, APT. 1206 BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** 1 M XXF Yrs 69 Director 212-48-9074 DEC. 17, 1926 MARYLAND Usuel Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director MARYLAND N/A BALTIMORE 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours effer death v Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than 'natural', or itema 23e and injury or other traumatic event, the Medical Exercises 2000. 1 WEST CONWAY STREET, APT. 1206 21202 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 Yes 2 No
It Yes, Give
Yeer or Detes: 1 □ Never Merried 2 □ Merried Bakimore, Maryland 21215-0020 1 ☐ Yes 2 XNo þ Specify: 3 ☐ Widowed 4 🖹 Divorced WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) 12 HOSPITALITY HOSTESS NIGHT CLUB 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be **JOSEPH** DOMINO CONCETTA GEPPI 2 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) THOMAS OVERTON/SON-IN-LAW 4623 BRIARCLIFT ROAD, BALTIMORE, MD 21229 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Remove from State FEB. 13, 4 ☐ Donetion 5 ☐ Other (Specify) 1996 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility LOUDON PARK FUNERAL HOME, Dink 23a. Part1. Entar tha disaasa, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229 Approximeta Intervel Between Onset and Deeth **Physician** /Medical Immediata Causa (Finel diseese or condition resulting in death) 9 months metastatic lung corner **Examiner** Dua to (or es e consequence of): Examiner The law requires that the death certificate be executed buriei-tran Sequentially list conditions, if any, leeding to Immadlete cause. Enter Underlying Cause (Disease or injury and Due to (or es e consequence ot) Box 68760. physician Physician/Medical that initieted events resulting in death) Lest the Due to (or es e consequence of): the ettending Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were sutopsy tindings evellable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peed hes 1 Yes 2 No certificate 1 ☐ Yes 2 PNo Attanding Physician: funeral director, 25. Wes case reterred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manne of Deeth 28e. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No or Attandi efter deeth Director: A deeth 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of injury - At home, ferm, street, tectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 I Homicide Hospital
 24 hours e
 Funeral D 29e. Certifian edical 1 Certifying Physicisn: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner es steted. completely (Check only one) 2 Msdlcal Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete snd plece, end due to the cause(s) end manner steted. To the I within 2 To the I 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D40850 12,1996 m Olm MD 30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print) YVONNE 900 CATONAVE BALTIMORE OTTAVIANO MD 32 Registrar's Signeture 31. Dete tiled (Month, Day, Year) State Soli: Moder Redall

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Registrar

FEB 1 3 1996

1 20 pt 4 11 JAN TALES - 300 THE GRAD THE SELECT The expression of the state of

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| | | | | Ce | ertificate o | f Death | | Reg. No | | | |
|--|----------------|---|---|-------------------------------------|--|--|---------------------------------|--|--------------------------------|--|--|
| Division | | 1. Decedant's Nama (First, Middla, | Last) | | | | 2. Data of De Month | ath | V | 3. Tima of Death | |
| Physic /Medi | | WERNER H. R. | BAUMGART | | | | | RY 4, 19 | Yaar 196 | 5:17 PM | |
| Exami | | 4a. Facility Nama (If not institution, g | riva street and number) | | | 4b. City, Town, or L | | | | | |
| | ,,,, | ST. AGNES HOSPI | | | | BALTIMO | DRE | N/A | 1 | | |
| Funeral Director | | 216-40-0875 | 1MM 2DE | yrs. last birthday | Months Day | | 8. Data of 2 1 (Month, 2 1 | Year) 24,1914 | 9. Birthpla Countr GER | nca (Stata or Foreign y) MANY | |
| P | | Usual Rasidance of Decedant 10a. Stata 10b. County | 10 | c. City, Town or I | Location | | | | 100 | d. Insida City Limits | |
| the Maryland 28s-f show sottfied at | Director | MARYLAND N/A | | BALTI | MORE | | | | | Yas 2□No | |
| € 68 | | 10e. Street and Number | | | 10f. Zip Coda | | | 10g. Citizen of 1 | What Countr | y? | |
| ath must | rai | 3700 MAC TAVISE | | | 212 | | | U.S. | | | |
| 21215-0020 d within 72 hours after death with the Maryla piene. r than "naturel", or litems 23a or 28a-f ahon the Madical Examinar must be notified at | by Funeral | 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Evar Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: | in U,S. 13 | . Was Decedent of If Yas, specify Cu 1 ☐ Yas 2 🗶 N | f Hispanic Origin? (Sp iban, Maxican, Puarto o <i>Specify:</i> | ecify Yas or No Rican, atc.) | | ca - Amaricar ck, Whita, at | | |
| 2 ho | ted | 15. Decedant's | | 16a. Dec | edent's Usuel Occ | upation | | 16b. Kind of B | | | |
| within 7 one. The Med | Completed | (Specify only highast (Elemantary/Secondary (0-12) | Collega (1-4or 5+) | (Giv lifa. | a kind of work don DO NOT use reti | a during most of work red) | ing | | | | |
| | Con | , (0 12) | 3 | F | BREWERY W | ORKER | | BRE | EWERY | | |
| C 0 = 0 5 | Be (| 17. Fathar's Nama (First, Middla, La | st) | | | 18. Mothar's Nam | | Maidan Suman | na) | | |
| arylas should b nd Ments merked umeric e | 10 | RUDOLPH BAUMO | ART | | | JOHANNA | A PRAI | NG | | | |
| Maryla d 2 should th and Mer T is merks traumetic | | 19a. Informant's Name/Ralationship | (Type, Print) | 19b. Mei | iling Addrass (Stree | et and Number or Rui | ral Routa Numb | er, City or Town, | Stata, Zip C | 2ode) | |
| 3 5 5 5 5 | | HILDE BAUMGART/ | WIFE | 370 | O MAC TA | VISH AVENU | JE, BAL | TIMORE, | MD 2 | 1229 | |
| ore, or Hear or Hear or other | | 20a. Mathod of Disposition | | Ob. Place of Disposematary, cr | position (Nama of ematory or other p | lace) | EB. 9. | 20c. Location - | City or Tow | n, Stata | |
| | | 1 ☐ Burlal 2 ☐ Cremation 3 4 ☐ Donation 5 【 Othar (Spec | | | , | 4.1 | 1996 | BALTIMO | DRE. M | ARYLAND | |
| Bafting Department Important: any lojury once. | | 21. Signature of Funaral Sarvice Lic | | | 22. Nama and Add | | 1,,,, | DIEDIAN | , ica, | THE LINE | |
| m Maria | | · anthony x | l Dime = | 3 | 3620 WIL | ARK FUNERA KENS AVENT | JE, BAL | TIMORE, | MARYL. | AND 21229 | |
| | | 23a. Part1. Enter the diseese, or co shock, or heert fellure. List on | mplications thet caused the ly ona ceusa on aach lina. | daath. Do not e | nter the mode of d | ylng, such as cardiac | or raspiratory a | rrast, | | Approximata Intarval Between Onsat and Deeth | |
| Physician | | Immediate Cause (Final diseese or condition rasulting in daeth) a. CARDIOPULMONARY ARREST | | | | | | | | | |
| /Medical Examiner | | | | | | | | | | | |
| | _ | Dua to (or as a consequence of): | | | | | | | | | |
| D is | al le | | ATHEROSC | LEROTIC | CARDIOVA | SCULAR DI | SEASE | | 4 | 20 years | |
| OX 68760, certificate be executed ading physician and use es the buriel-transit | Examiner | Sequentielly list conditions, if any, leading to immediate cause. Enter Undarrying DTARFTES MELITITIS | | | | | | | | | |
| 50, be ey | | | | | | | | | | | |
| 68760 ficata be e physiciar as the buri | edical | that initiated events rasulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| X e iii e | 3 | | | | | | | | | | |
| ofte of the for us | lan | | v | | | | | | | | |
| cords, P.O. Bo requires that the deeth seen signed by the atter hould be detached for a | Physician/ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute | | | | | | | | | |
| d by detacle | Ph | 1 Yes 2 No 3 P | | | | | | | | Probably Unknown | |
| as the digner of | by | | | | | | | | | | |
| cord require been si should | Completed | | | | | | | an autopsy med? | avail | a autopsy findings lable prior to | |
| | ple | | | | | | | | of de | pletion of cause eath? | |
| T 0 - 6 | NO. | | | | | | 10 | Yas 2 No | 10 | Yas 2□ No | |
| VITAL I | Be (| 25. Was case rafarred to medical | | | | 28. Placa of Deat | h (Chack only o | ona) | | | |
| T V | To | axaminar? 1 ☐ Yas 2 🛣 No | Hospital: 1 Inpatiant | 2X ER/Outpatio | ent 3 DOA | Xhar: 4□ Nursing Ho | me 5 Resid | dence 8 Oth | ar (Specify) | | |
| DIVISION OF VITA or Attending Physician: after death. Director: After this certific Jin by the funeral director, | Certification: | 27. Menner of Death 1 XNaturel 5 Panding 2 Accidant Invastigati | 28a. Data of Injury (Month, Day Yea | 28b. Tima Injury | W | ury at ork? □ Yas 2 □ No | 28d. Dascribe | Dascribe how injury occurred Location (Street and Number or Rural Route Number, | | | |
| Attendi r death. ctor: A yy the fu | fice | 3 ☐ Sulcida 6 ☐ Could not | | At homa, farm, s | treet, factory, office | 9 | 28f. Location (| | | | |
| | erti | 4 ☐ Homicida | building, afc. (S | pecify) | ,, | | City or To | vn, Stata) | | | |
| To the Hospital of within 24 hours af To the Funeral Discompletely filled in | edicai C | (Check only 2 Medical Ex | hysician: To the best of my iminer: On the basis of axa | knowledga, daa mination and/or i | th occurred at tha | tima, data and place, | and due to the | causa(s) and ma | inner es stat | led. | |
| the the upper | Med | one) | and mannar stated. | | | | | | | | |
| 5 ₹ 5 8 | 7 | 29b. Signatura and titla of certifier | am it. | | 29C. Licar | nsa number | | 29d. Data signe | d (Month, De | ly, Year) | |
| 1 | | Jun 7 | | | D47 | 353 | | FEBRUAR | RY 4, | 1996 | |
| 2 | | 30. Nama and addrass of person wh | completed causa of daath | (Itam 23a) (Type | , Print) | | | | | | |
| | | JON FALCK, M.D. | | | TAL, 900 | CATON AVE | NUE, BA | LTIMORE, | MD 2 | 1229 | |
| Sta | | 31. Data filed (Month, Day, Year) | 32. Registrer's S | Signature | | | | | | | |
| Registr | ar | FEB1 31996 | inva d'autres de | Half | | | | | | | |

All there is the fact of the second of the s

Item#12.G-film 732 per FH.2/2/2/96 Pic State of Maryland / Department of Health and Mental Hygiene 96 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 8,1996 John Feb. Benson, Jr. 3:P.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 9475 Hickory Limb Columbia Howard Co.Md. If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Yeer 5. Sociei Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days X□M 2□F 77 Yrs. Director 213-05-5661 Aug, 6, 1918 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Balto.City, Md. N☐Yes 2☐No Director Maryland none 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 E. Heath St 21230 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? NAVY
1 Types 22 NoW W
If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items any injury or other traument. 1 Never Married 2 ☐ Married Yes 24 No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Transport Elementery/Secondary (0-12) College (1-4or 5+) Dispatcher Mountain Side 11th.Grade none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be John H.Benson, Sr. Louise Jenny Young 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) Mrs. Joan L. Simmons 2732 Marbourne Ave.Balto.Md. 21230 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery2/10/96 A.A.Co.Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Md.21230 McCully Funeral Home, 130 E. Fort ave.Balto. Maynad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final VAMOUS COLU CARCHAMIA OF LYNG disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown ģ icate has been sig r, page 2 should b Completed 24b. Were autopsy findings evailable prior to 24e. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Certification: To 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Proaturai 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signatura and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

the Maryland

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

and physician s the burial

for use as

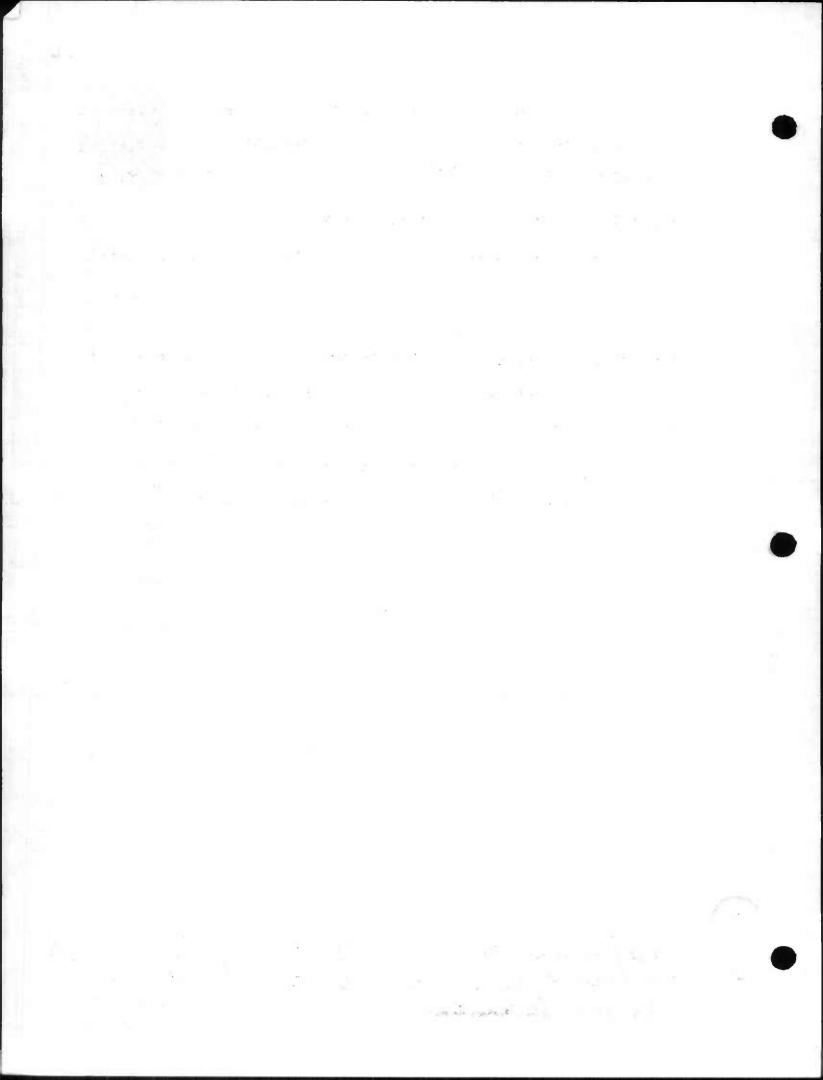
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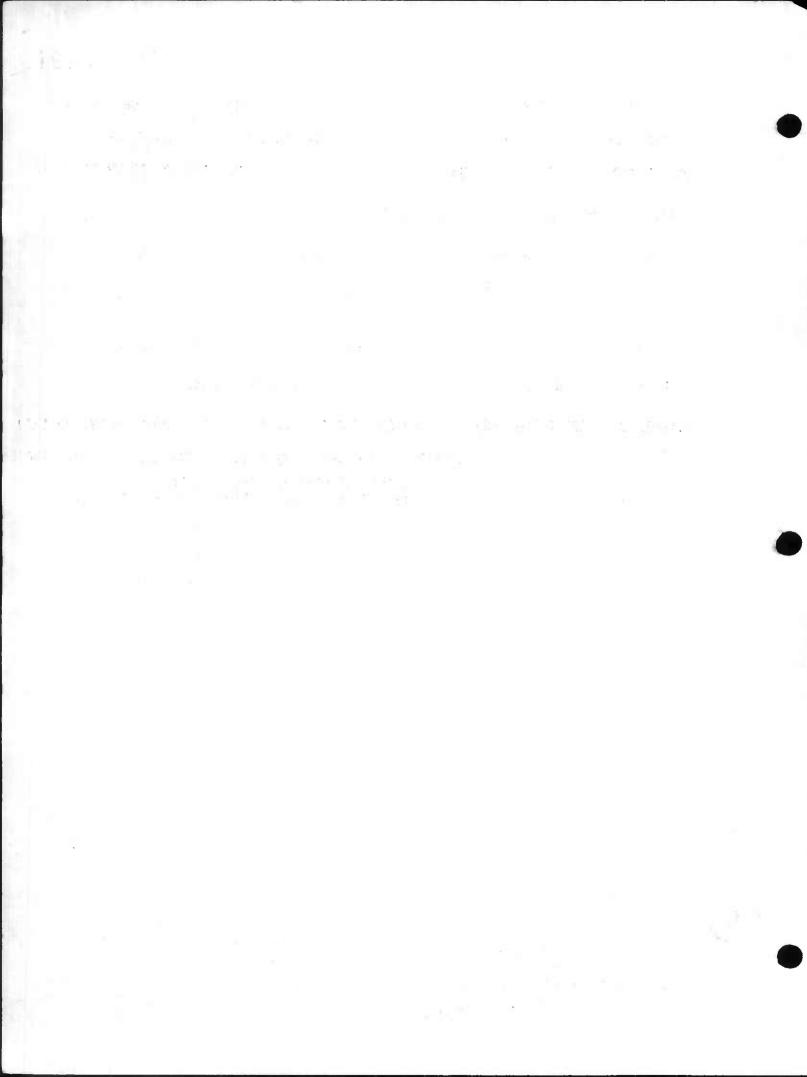
mpleted cause of death (Item 23a) (Type, Print) 2. Registrer's eigns



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien.

| | | 79.9 | Certificate of D 1. Decedent's Neme (First, Middle, Last) | Death | | Reg. Nc | 96 | 03516 | |
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| ı | Physic /Medi | | LEROY BAKER | | Month | 8ey | 96 | 9:35 PM | |
| | Exami | | | o. City, Town, or Local CATONSVILI | | | Inty of Deeth | | |
| 2 | Funeral Director | | 5. Social Security Number 247 – 22 – 4831 6. Sex 10 M 2 F 83 7 F. Age (In yrs. last birthday) 6. Sex 10 Months 10 Days 10 Usuel Residence of Decedent | if Under 24 Hrs. 8 Hours Min. | 3. Dete of Birth Month Det 06/12 | 71912 | 9. Birth | HOLD CAROLINA | |
| | Meryland a-f show | tor | 10a. State 10b. County 10c. City, Town or Location | | | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No | |
| | 23e or 28 | ral Director | | 229 | | 10g. Citizen | of What Cou | | |
| 020 | 72 hours after death with the Meryland natural", or flems 23a or 28a-f show dical Examinet must be notified at | by Funeral | 3 Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☑ No | | ity Yes or No- ican, etc.) | | Race - Amen Bleck, White acify: BL | | |
| Maryland 21215-0020 | within ene. then | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12 15. Decedent's Usuel Occupation (Give kind of work done du life. DO NOT use retired) LONGSHOREMAN | tion uning most of working | | 16b. Kind of Business/Industry LABORER | | | |
| yland | should be filed ind Mentel Hygi i marked other umatic event, ii | To Be C | 17. Fether's Neme (First, Middle, Last) WESLEY BAKER | 18. Mother's Neme (i | or's Neme (First, Middle, Melden Sumeme) ILLIE BAKER | | | | |
| Jar | 2 she nand is me | | 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street en | nd Number or Rural F | Route Numbe | er, City or Tox | wn, Stete, Z | ip Code) | |
| Baltimore, N | mit. Pages 1 end vartment of Heelth cortant: if item 27 injury or other to | | MILDRED B. MOORE (DAUGHTER) 20a. Method of Disposition Cameleny, cremetory or other place) 4 Donation 5 Okher (Specify) 304 SOUTH CAT 20b. Place of Disposition (Name of cameleny, cremetory or other place) WESTERN STAR CEMET |) | Date | 20c. Locatio | on - City or T | | |
| Balt | Departm Departm Importar any injur | | 21. Signeture of Fuseral Service Licenses E2. Nerre and partners E3. TEP BROTH 1300 EUTAW | | | | LAND | 21217 | |
| 1 | Physician | | 23a Part 1. Egitor the disease, or complications that reused the death. Do not enter the mode of dying, shock or heart failure. List only one cause or lead line. | , such es cardiac or r | respiretory ar | rest, | | Approximete Interval Between Onset end Deeth | |
| ľ | /Medical Examiner | <u></u> | Imm. Jate Cause (Finel disease or condition resulting in death) e. Due to (or as a consequence of): | ant for | line | <i>L</i> > <i>l</i> | | 10 | |
| ·, | icate be executed physician and s the buriel-transit | Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es a consequence of): Due to (or es a consequence of): | tive /K | ent 1 | dis | ene | 10 905 | |
| 68760, | tificate be executed g physician and es the buriel-transit | edical | Ceuse (Disease or Injury that initiated events resulting in death) Lest Compared to the first of the compared to the compared | In Ca | ~ | 1 , ,, | | | |
| Box | death cer e ettendin ed for use | lan/A | d. I her nee, | you ! | thent | 19 | 1 | 69.5 | |
| P.0. | ires that the death certifications signed by the ettending does detached for use ea | Physician/W | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given | n in Part I. | 23b. Did t | _/ | | to the ceuse of death? | |
| Vital Records, | aw requisite been 2 should | Completed by | | | | en autopsy med? | 9 | Vere autopsy findings vallable prior to completion of cause of deeth? | |
| a R | E age | | | | 1 🗆 Y | 0 | 1 | ☐ Yes 2☐ No | |
| | Physician: this certific ral director, | To Be | 25. Wes case reterred to medical exeminer? 1 | 7: 4 Nursing Home | | | Other (Spec | nifu) | |
| ion of | or Attending Physician: after death. Director: After this certific in by the funeral director, | | 27. Menns Death 1 District Signature | at 28 | d. Describe h | | | , | |
| Division | ital or Atta | Certification: | 3 Sulcide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) | 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | | | |
| | 1 | Madical | 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, (Check only one) Certifying Physician: To the best of my knowledge, (Check only one) Certifying Physician: To the best of my knowledge, (Check only one) Certifying Physician: To the bes | inion, deeth occurred | et the time, o | dete and pled | ca, and due t | to the cause(s) | |
| | 2 28 | | 290. Signature find title of certifier Physican 29c. License r | 2976 | 9 | 29d. Dete sig | 13 | 196 | |
| | Sto | ** | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture | 16 N. K | Rolli'u | y kd | 3 | n(A. | |
| | Sta Registr | | FEB1 3 1996 de director Redall | | 4 | 7 | | | |

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State of Maryland / Department of Health and Mental Hygien Q C

| _ | | | | | | Certific | | Death | F | Reg. Nc | -0. | 1100 | | |
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| Physician | | | Decedant's Nama (First, Middle, Las.) | | | 2. Data of Dea | 2. Data of Death Month Day Yea | | 3. Time of Death | | | | | |
| /Medical | | | Grace Barn | | | Februa | | 996 | 6:20 AM | | | | | |
| Examiner | | | 4a. Facility Nama (If not institution, giva | street and number) | | | | 4b. City, Town, or Location of Death 4c. County ot Death | | | | | | |
| | | | Lorien Nursing Hor | ne | | | | Columbia | | Howa | rd | | | |
| | Funeral | Г | 5. Social Sacurity Number 6. Se | x 7. Age | a (In yrs. la: | st birthday) If U | ndar 1 Yaar | If Undar 24 Hrs | 8. Data of Birt (Month, Day | | | aca (Stata or Foraign | | |
| п | Director | | 579-20-4741 | □M 2□kF | 71 | Yrs. | ths Days | Hours Min. | March 1 | 5. 1924 | New | Jersev | | |
| | D. | 1 | Usual Rasidance of Decedant March 15, 1924 | | | | | | | | | ocracy | | |
| | how | ١. | 10a, Stata 10b. County 10c, City, Town or Location | | | | | | | | | | | |
| | Me Me | Director | MD Anne Art | | | | 1 Yas 2 No | | | | | | | |
| | r 28 | ě | 10e. Street and Number | 22.00 | | enton | . Zip Coda | | | 10g. Citizan of V | Vhat Count | ry? | | |
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| | s within 72 hours after death with the Meryland ilene. Then "natural", or ferms 23a or 28a-f show the Medical Examinet must be notified at | Funeral | 11. Marital Status | 12. Was Decedant B | Evar in U.S. | | | dispanic Origin? (S | pecify Yas or No- | Unite | e - Amarica | | | |
| | the the | F | 1 ☐ Navar Married 2 ☐ Marriad | Armed Forces? | | | | lispanic Origin? (S an, Maxican, Puan | o Rican, etc.) | Blac | k, Whita, a | | | |
| 320 | irs a | by | 3 ₩idowed 4 Divorced | 1 ☐ Yas 2 ☐ N If Yas, Give X Yaar or Datas: | | 1 □ Ya | as 2⊠No | Specify: | | Specify | . Whi | te | | |
| 21215-0020 | tura fura | 8 | 15. Dacedant's Edu | cation | 1 | 16a. Decedant's | Usuai Occur | pation | | 16b. Kind of Bu | singes/Indi | uetry | | |
| 15 | C | Completed | (Specify only highast grad | la completed) | | (Giva kind o | f work dona OT usa retire | dona during most of working retired) | | | | | | |
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| P | be filed that Hygie d other | | 17, Fathar's Nama (First, Middla, Last) | U | 1 | IOUSE WIT | LE | 18. Mothar's Nar | na (First, Middla, | Own H | | | | |
| an | od o od o | Be | Emerson R. Johnson | 1 | | | | | tte Cros | | -/ | | | |
| 2 | d 2 should be filed with h end Mental Hygiene. 7 is marked other than traumatic event, the M | 10 | 19a. Informant's Name/Raiationship (T | | | 40h Afrillon Ada | | and Number or Ru | | | Oil in Wind | 0.41 | | |
| Maryland | | | James L. Barnett/so | , | h | - | | Road Od | | | | | | |
| | Health Health em 27 | | 20a. Mathod of Disposition | | - | ce of Disposition | | . Road od | Data Data | 20c. Location - | | | | |
| ō | 報を書る | | 1 ☐ Buriai 2 ☐ Cramation 3 ☐ F | | can | natary, crematory | or othar pla | 1 | 2000 | 200. Location - | City Of 100 | m, Stata | | |
| Baltimore | | | 4 □ Donation 5 □ Other (Specify) | | Balt | | | ton Crem | 2/8/96 | Laurel | , Mar | yland | | |
| Sal | Departs Departs Imports any Inja | - | 21. Signature of Funeral Service bicens | 7 // | | | | ss of Facility | | | | | | |
| - | 00759 | Fleck Funeral Home, Inc. | | | | | | | | | | 1 MD 20707 | | |
| | | 7601 Sandy Spring Road, Laurel, MD 2070 23a. Paryl. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appropriately one cause on each line. | | | | | | | | | | | | |
| 9. | Physician | | | | | | | | | | | intarval Batween Onsat and Death | | |
| A. | /Medical | | immediate Causa (Final disaasa or condition rasuiting in daath) a. As piration pulled once Idea Idea Dua to (or as a consequence ot): b. Siwallowing dysfunction mains | | | | | | | | | | | |
| | Examiner | | rasuiting in daath) | a. 942/5 | Due to (or a | IS A CONSEQUENCE | ot): | | | | | rathes. | | |
| | | ner | | . / | 4 | | 1,66 | 101/16 | 10.4 | | | visitle. | | |
| | outec nd nansi | Examiner | Sequentially list conditions | | | is a consequence | 00: | 2000 | OV | | | | | |
| oʻ | ifficate be executed g physician end as the burial-transit | EX | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | 110005. | | |
| 68760, | ysick e bu | edicai | Causa (Disaasa or injury that initiated evants | 0. 110091 | Due to for a | s a consequenca | of): | ray | 36/6/0 | 2012 | | years | | |
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| 0 | seath e ette | icia | Dort II Other significant conditions | at the sales are already to | A A (A) | Contract of the | Si Laib Cr | | 001 0111 | | | | | |
| 0.0 | the da | Physician/N | Part II. Other eignificant conditions con | /an in Paπ I. | | the cause of death? | | | | | | | | |
| | requiras that the death cer wen signed by the ettendir hould be detached for use | | | | | | | | 101 | 20 No | 3 Prob | ebly 4 ☐ Unknown | | |
| Vital Records, | sign id be | d by | | | | | | | 24a Was | an autopsy | 24b. Wai | ra autopsy findings | | |
| Š | v requir been si should | ompieted | | | | | | | perfo | med? | con | ilabla prior to | | |
| Š | 2 60 8 | du | | | | | | | | | of d | leath? | | |
| <u></u> | cata ha | ပိ | | | _ | | | | 1 🗆 Y | as 2 No | 10 | Yas 2 No | | |
| ======================================= | Physician: The this certificata ral director, pag | Be | 25. Was casa ratarrad to medical axaminar? | do amital. | | | 100 | | ath (Check only o | | | | | |
| of | 0 0 | 5 | 1 185 208110 | 1 | | | JOOA | | loma 5 🗆 Rasid | lance 8 DOth | ar (Specify, |) | | |
| | ding P. h. After t funera | on: | 27. Mannar of Death 12 Natural 5 Panding | 28a. Data of injury (Month, Day | Year) 2 | 8b. Tima of Injury | 28c. Inju | ry at rk? | 28d. Dascribe h | low Injury occur | ed | | | |
| S | Attending Ph er death. ector: After th by the funeral | Sati | 2 ☐ Accidant invastigation | | | М | 1 🗆 | Yas 2□No | | | | | | |
| Division | l or Attendent efter deat Director: | ertification: | 3 Suicida 6 Couid not be detarmined | 28a. Piaca of Inju building, atc | ry - At hom | a, farm, street, fa | ctory, offica | | 28f. Location (S City or Tow | Street and Numb n, Stata) | er or Rural | Routs Number, | | |
| | pital or ours effe erai Dir | Ce | | | . (-,,) | | | | | , , | | | | |
| | dy file | Cai | 29a. Certifying Physical Exami | ician: To the bast o | t my knowle | adge, death occur | rred at tha ti | ma, date and place | , and due to the o | ause(s) and ma | nnar as sta | ited. | | |
| 1 | 100 | edical | one) | ner: On the basis of and mannar stat | axaminatio led. | n and/or invastiga | ition, in my o | ppinion, death occu | irred at tha tima, o | data and place, | and dua to | tha cause(s) | | |
| 29b. Signatura and titla of certifiar 29c. Licansa number | | | | | | | | 1.2 | 29d. Data signe | d (Month, D | lay, Year) | | | |
| 1 | | | Redland. | late Our | 40 | 1- | \rightarrow | 3157 | - | Feh | 7.1 | 59/2 | | |
| | 1 | | 30. Nama and addrass of person who co | omplated cause of de | ath (Item) | 3a) (Type Print) | ***** | | 4 | , -,5 | () ' | . , . | | |
| | 0 | | 9501 0Pd | | olis | 2 and | 811 | w#6 | et 1 | 20 21 | 047 | | | |
| | Sta | te | 31. Data tiled (Month, Day, Year) | -32. Registra | | ra - CONYO | 011 | 20 17 | 7 | - 40 | | | | |
| | Registr | _ | FFR 1 9 100C | 111 143 | 0 . | | | | , | | | | | |

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State of Maryland / Department of Health and Mental Hygien 96 035 | 8

| | | | | | | Certifica | te of | Death | | | Reg. Nc | _ | | |
|---------------------------------|--|----------------|---|--|--------------------------|-------------------|-------------------------|-----------------------------------|--------------|-------------------------------|----------------------|-------------------|--------------------------------------|-------------|
| | - | | 1. Decedent's Neme (First, Middle, La | ist) | | | | | | 2. Dete of De | eth | 1/80 | 3. Time of D | eath |
| Physiciar /Medica Examine | | | LEONARD | BRAV | BRAVE | | | | FEBRUA | ARY 7,19 | 96 | 8:30ai | m | |
| | | | 4a. Facility Neme (If not Institution, give | re street and number) | | | | 4b. City, To | wn, or Lo | ocation of Deat | | | | |
| | Exami | 101 | 5807 BERKELEY AV | /ENLE | | | | В | ALTI | MORE | N/A | | | |
| | Funeral | | | | e (In yrs. last bin | thdey) If Und | er 1 Yeer | | | | | | lace (Stete or F | Foreign |
| | Director | | 212-01-7794 | 1 M 2 F 89 Yrs. Months Deys | | | | | Min. | (Month, De | 13,1906 | MAR | MARYLAND | |
| _ | | | Usuel Residence of Decedent | | | | | | | 00112 | 20,2500 | | | |
| | yland | | 10a. Stete 10b. County | | 10c. City, Town | n or Location | | | | | | 1 | 0d. Inside City | Limits |
| | Me | to | MARYLAND N/A | | | BALTIMO | ac | | | | | | 1 XYes 2 | □No |
| | 28. For | Director | 10e. Street and Number | | | | ip Code | | | 1 | 10g. Citizen of \ | What Cour | ntry? | |
| | 3a o | 0 | 5807 BERKELEY A | VE. | | | | 2 | 1215 | | USA | | • | |
| | Jeath 2 | Funeral | 11. Meritel Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (S | | | | | | ain? (So | acify Yes or No | - 14. Rec | a - Americ | an Indian | |
| | far far | Ē | Armed Forces? If Yes, specify Cuben, Mexican, Pue | | | | | , Puerto | Rican, etc.) | | ck, White, | | | |
| 070 | or, ja | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Yeer or Detes: | | 1 ☐ Yes | 2 XNo | Specify: | | | Specify | y: WHITE | | |
| 9 | Jwithin 72 hours after death with the Meryland jiene. r then "neturel", or ferme 23a or 28a-f show the Medical Examiner must be notified at | Completed | 15. Decedent's E | ducation | 16a. | Decedent's Us | uei Occu | pation | | | 16b. Kind of B | Business/Industry | | |
| 218 | | ple | | (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5- | | | rork done use retire | during mos | t of work | ing | | | | |
| 21 | filed within Hygiene. ther then out, the Me | E | 12 | College (1-40r 5 | College (1-4or 5+) AGENT | | | | | | INSU | RANC | E | |
| P | 量支電车 | Bec | 17. Father's Neme (First, Middle, Last |) | 18 | | | 18. Mother's Neme (First, Middle, | | | , Melden Suman | 10) | | |
| ja | O TO O | ToB | MEYER | | BRAVE SARAH | | | | RAH | H SOLOMON | | | | |
| Maryland 21215-0020 | d 2 should be the and Mental it is marked of treumatic eventage. | - | 19e. Informent's Neme/Reletionship (| Type, Print) | 19b | . Melling Addre | ss (Stree | t end Numbe | er or Rure | al Route Numb | er, City or Town, | Stete, Zio | Code) | |
| | 25.2 | | MRS. ERMA BRAVE | (MIEE) | | _ | | | | | RE,MD 2] | | | |
| re, | T & E E | | 20e. Method of Disposition | (MTEE) | | Disposition (N | eme of | | | Dete | 20c. Location - | | wn, Stete | |
| 100 | age: ont of t: If I | | 1 Buriel 2 □ Cremetion 3 □ | | | y, cremetory or | | 100) | 2-8- | -1996 B | ALTIMORE | E, MD | | |
| Baitimore, | permit. Pages 'Department of H Important: If he any injury or of once. | | 4 Donetion 5 Dotter (Specify) BETH TFILOH 2-8-1996 BALTIMORE, MI | | | | | | | | | | | |
| Ba | Depa Impo any i | | 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. | | | | | | | | | | | |
| | | | Memme | , durin | Non | 6010 | REI | STERSI | NWO | ROAD B | ALTIMORE | E, MD | 21215 | |
| | | , , | 23a. Pert1. Enter the disease, or com shock, or heart feilure. List only | pilcations that caused one ceuse on eech lir | the death. Do r ne. | not enter the mo | ode of dyi | ng, such es | cardlec o | or respiretory e | rrest, | | Approximate Interval Betwe | en |
| | Physician | | Vertile State Control | / | 2 | 11 | | | | | | i | Onset and De | |
| | /Medical Examiner | | Immediate Cause (Fine) disease or condition resulting in deeth) e. Prostate Cancar | | | | | | | | Xear | 7 | | |
| Н | | _ | Due to (or es a consequence of): | | | | | | | | | | | |
| | Si ed | Examiner | | b. ————— | | | | | | | | | | |
| | entificate be executed ding physician and sa as the burial-transit | хап | Sequentially list conditions, if any, leading to immediate | | Due to (or es e o | consequence of |): | | | | | | | |
| 68760, | be exician buria | | Cause (Disease or injury | | | | | | | | | | | |
| 387 | phys the | edical | thet initieted events resulting in death) Last Due to (or es a consequence of): | | | | | | | | | | | |
| × | 5 = 5 S | Me | L | d | | | | | | | | i | | |
| å | 6.3 | | | | | | | | | | | i | | |
| Ö | 0 0 0 | Physician | Pert II. Other significant conditions of | contributing to death bu | ut not resulting in | the underlying | cause gi | ven in Pert i. | | 23b. Did | tobacco use co | ntributa to | the cause of | death? |
| P. 0. | es that the death igned by the atta be deteched for | | Sovere ov | TRYIOS. | devo | 114 | d | 560 | 50 | 10 | Yaa 27 No | 3 ☐ Prol | bably 4 Un | known |
| Records, | The law requires that the te has been signed by the baga 2 should be deteche | by | | | | | - | | | | Tur a comment | | 1155 T. T. B. B. B. | |
| O | v require been si should I | Completed | | | | | | | | | en autopsy ormed? | av | are autopsy find aliable prior to | |
| ec | has b | pie | | | | _ | | | | | | of | mpletion of cau death? | 50 |
| | The ate h | 5 | | | | | | | | 10 | Yes 20 No | 10 | Yes 2□No | 0 |
| ā | ysician: The last contificate had director, paga | Be (| 25. Wes case referred to medical examiner? | | | | | 26. Plece | of Deeth | Check only | one) | | | |
| > | Physic this ce al dire | To | 1 ☐ Yes 2 No | Hospitel: 1 ☐ Inpatle | nt 2 ER/Out | tpatient 3 🗆 🖸 | Otl | her: 4 🗆 Nu | rsing Ho | me Hosi | denca 8 □Oth | er (Specit | y) | |
| 0 | | | 27. Manner of Death | 28a. Date of Injur (Month, Day | | ime of | 28c. Inju Wo | ry et | | 28d. Describe | how injury occur | red | | |
| <u>ō</u> | ath. r: Af | atic | Neturel 5 Pending investigation | | | М | | Yes 2□I | No | | | | | |
| Division of Vital | or Attending after death. Director: After I in by the fune | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | e 28e. Pleca of Injubuilding, etc | ry - At home, fai | rm, street, fecto | ry, office | | | 28f. Location (City or To | Street and Numb | er or Rura | I Route Numbe | f, |
| ō, | pitti or y our after met Directilled in b | Çe | A . | John Marie Control | . (0,000,7) | | | | | | ,, | | | |
| 6 | To the Hospithi or with a Moura after To the Furner Dir completely filled in | Ca | 29e. Certifiler (Check only) Certifying Ph | yalclan: To the best of | f my knowledge, | deeth occurre | d el the ti | me, dete en | d plece, a | and due to the | cause(s) and ma | nner as si | ated. | |
| _ | Plate at at | edical | one) | end manner sta | ted. | vor investigetio | n, in my c | эріпюп, авв | in occurri | ed et the time, | dete end piece, | and dua (c | the cause(s) | |
| | To the To the comple | Σ | 29b. Signeture end title of certifler | 1411 | MI | 2 | 9c. Licens | se number | | | 29d. Date signe | d (Month, | Dey, Year) | |
| | E | | don | Mone | NW | 140 | | 240 | 53 | 2 | Fo | 6 | 7 19 | 96 |
| | 2 | ŀ | 30. Neme and address of parson who | completed cause of de | eth (Item 23a) (| Type, Print) | | | , | | | Anh | Pimari | - |
| | | | DAVID A | VAN E | c 40,1 | np. | 22 | Sout | 10 6 | 12048 | e st | m | PIVIGY | 16 |
| | Sta | te | 31. Date filed (Month, Dey, Year) | 33 Registra | ir's Signeture | | | , , | | 750 | | | 1 | han War war |
| | Registr | | FEB 1 3 1996 | guna Dayidson | n-Mondale | 2 | | | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene Q C

| | | | Decedent's Name (First, Middle, L | Otate of Ivial yie | | ertificate of | | Re | g. No | 3. Time of Death | | |
|-----------------------|---|----------------|--|---|--|--|--|--|--|---|--|--|
| | Physici | | JOSEPH | ası) | BERN | STEIN | | 2. Date of Death Month FEBRUAR | BRUARY 8,1996 3an | | | |
| | /Medi Examir | | 4a. Facility Name (If not Institution, g | iva street and number) | | | 4b. City, Town, or L | | 4c. County of Deat | h | | |
| | | | 9719 BRANCHLEIGH | ROAD | | | RANDALL | | BALTIMOR | | | |
| | Funerai Director | | 5. Social Security Number 6. 215–32–7164 Usual Residence of Decedent | Sax 1 M 2 F 7. Aga (In y. | rs. last birthda Yrs. | y) If Undar 1 Yaar Montha Days | If Under 24 Hrs. Hours Min. | 8. Data of Birth (Mooth, Day, AUG. 1 | 5,1904 RUS | hplaca (Stata or Foreign | | |
| | yland | | 10a. State 10b. County 10c. City, Town or Location 10d. Inaida City I | | | | | | | | | |
| | a-fal | ctor | MARYLAND BALTI | MORE | | RANDALLST | OWN | | | 1 Yes 2 No | | |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | 10g. Citizen of What Country? | | | |
| | a 23a | | 9719 BRANCHLEIGH | | | | 21133 | | USA | | | |
| 020 | hours after death with the Maryland hurst, or items 23s or 28s-f show all Examine frust or notified at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Evar in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: | 1 U,S. 13 | 8. Was Decedent of No. If Yes, apecify Cub | | pecify Yes or No- Rican, atc.) | 14. Race - Ame Black, White Specify: WI | | | |
| 2 | 2 = 2 | eted | 15. Decedent's I (Specify only highast g | Education rade complated) | 16a. Dec | edent's Usual Occup | pation during most of work | dog 1 | 6b. Kind of Buainess/ | Industry | | |
| 121 | | Completed | Eiemantary/Secondary (0-12) | College (1-4or 5+) | | ve kind of work done . DO NOT use retire | | | MENS FURNI | CHTMCS | | |
| 9 | filed Hygi | | 17. Fathar's Nama (First, Middle, Las | () | OV | VNER-OPERA | | a (First, Middle, M | | DITITOO | | |
| /lan | A P P P | To Be | SIMON | 1 | BERNSTE | EIN | SARA YANKELOVI | | | OVITZ | | |
| , Maryland 21215-0020 | d 2 sho th and I | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. SARA KANEFSKY (DAUGHTER) 4013 AMY LANE RANDALLSTOWN, MD 21133 | | | | | | | | | |
| Baltimore, | permit. Pages 1 and Department of Healt Important: If Item 21 any Injury or other once. | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec | Removel from State | D. Place of Dis cemetery, cr LINGTON | position (Name of rematory or other pla N—CHIZUK A | MUNO 2-9- | Data 20 -1996- BA | Oc. Location - City or LTIMORE, N | Town, State | | |
| Balt | pemit. Departi Import any in | | 21. Signeture of Funeral Service Lice | ansee Cathles | | | EVINSON 8 | | INC. TIMORE, MI | 21215 | | |
| | Physician /Medical Examiner | Examiner | 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition rasulting in death) | · Cerel | o (or as a cons | Vacal | Par 1 | Acc. 1 | Sul | Intarval Between Onset and Death | | |
| Box 68760, | h certificate be executed anding physician and r use as the burial-transit | edical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | (or as a cons | , | | | 1 | U | | |
| | s deat | Physician/M | Part II. Other algnificant conditions | contributing to death but not r | esulting in the | underlying cause giv | van in Part I. | 23b. Did tob | acco use contribute | to the cause of death? | | |
| , v. | requires that the death cen been signed by the attandin should be detached for use | by Phy | | | | | | 1 🗆 Yaq | 2 No 3 Pr | obably 4 Unknown | | |
| Vital Records, | ≥ 8 N | Completed | | | | | 7 | 24a. Was an performe | ed? | Nere autopsy findings available prior to completion of causa of death? | | |
| E | E # 8 | | | | | | | 1 ☐ Yes | 2 1 No 1 | Yes 2 No | | |
| \frac{1}{5} | delan certifi recto | o Be | 25. Was case referred to medical examinar? | Hospitai: | | Ott | AOP! | h (Check only one | | | | |
| 0 | Attending Physician: or death. ector: After this certific by the funeral director, | - | 1 Yes 2 No. 27. Manner of Death | 28a. Date of Injury | 28b. Tima | of 28c. Injui | y at | oma 5 Rasiden 28d. Dascribe hov | ce 8 Other (Spec | city) | | |
| <u></u> | ath. r: Afte | atloi | 1 Natural 5 Pending 2 Accident investigation | (Month, Day Year) on | Injury | Wo | rk? Yes 2 □ No | | | | | |
| Division of | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral | Certification: | 3 Suicide 6 Could not determined | | homa, farm, a | atreet, factory, office | | 28f. Location (Stre City or Town, | eet and Number or Ru State) | ral Route Number, | | |
| | To the Hospital or I within 24 hours after To the Funeral Director Completely filled in b | Medical | 29e. Certifier (Check only one) | nyaician: To the best of my k miner: On the basis of exami and manner stated. | nowledge, dee netion and/or i | oth occurred at the tir investigation, in my o | me, date and placa, pinion, deeth occur | and due to the cau red at the time, dat | use(s) and manner aa te a <i>n</i> d place, and due | stated. to the cause(a) | | |
| | o the | Me | 29b. Signature and title of certifier | and marrier stated. | | 29c. Licens | se number | 290 | d. Date aigned (Monti | n, Day, Year) | | |
| | | | DAUGE | (DM. | | Do | 698U | | 2-9. | -96- | | |
| | | - | 30. Name and address of person who | completed cause of death (It | em 23a) (Type | e, Print) | .1 | ^ | - 1 | 19 | | |
| | | | 10219 5,1 | | DWIN | 165 Mi | ils, Ms | D 211 | 117 | | | |
| | Sta Registr | | 31. Date tiled (Month, Day, Year) FFR 1 2 1006 | 32. Registrar's Sig | natura | 7 | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 9 6

Certificate of Death 1, Decedant's Nama (First, Middla, Last) 2. Data of Death 7^{Day} Month **Physician** Richard Broderick, Jr. Charles Feb. 1996 10:45 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 28 Chatsworth Ave. Glyndon Baltimore Hours Min. 6. Date of Birth (Morth, Day, Year)
March 13, 6. Sex 1 M 2 □ F If Undar 1 Year 5. Social Security Number 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) **Funeral** Days Maryland 212-07-5676 78 Yrs. 1917 Director Usual Rasidance of Decedant pemit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Inspartment of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 23s-f show any injury or other traumatic event, the Medical Examinal must be notified as once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Md. Baltimore **Glyndon** 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 28 Chatsworth Ave. 21071 USA Funerai 12. Was Decedent Evar in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: WW II Was Dacedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🖾 No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Owner Distr. Company 17, Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charles R. Broderick Sr. Anna McNultz 19a. Intormant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Elizabeth Broderick 28 Chatsworth Ave. Glyndon, Md. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Garrison Forest Vet. Cem. 2-12-96 Owings Mills, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensee 22. Nama and Addrass of Facility 11824 Reisterstown Road Reisterstown, Md. 21136 Eline Funeral Home amo cone 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, hock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Squamous cell Cancer, Isophyos /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physician and the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) USB 88 Pop signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3☐Probably 4☐Unknown ģ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed Deen completion of cause of death? hes 1 Tas certificate r Atending Physicien: The ordesth. 25. Was casa rafarred to medical Be 26. Place of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 25 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Data ot Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of Certification: Natural 5 Panding 1 Yas 2 No Invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, streat, tactory, office building, atc. (Specify) 4 Homicida Hospital 24 hours a 24 hours 29a. Cartifier (Check only 15 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. Medical 2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and titla of certifia 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print) James A. Quinlan, M.D. 7801 York Rd. Suite 100 Towson, Md. 21204 31. Data tiled (Month, Day, Yaar) 32. Registrar's Signatura State Tali Dan Bear Revolate FEB1 3 1996 Registrar

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| | 1, 2, 3 should | |
|------------------------------|--|---|
| | Pages 1 | |
| atai or attending physician. | is director, page 5 should be detached for use as the burish-transit permit. Pages 1, 2, | |
| the hotp | detache | Dince. |
| retained by t | 5 should be | e notified at |
| may be | 00, 2404 | ust be |
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| Jeath ce | attendin mtal Hyg | ry, or 0 |
| hat the | and Me | ny inju |
| equires that the dea | ertificate has been signed by the attending physician and the State Dept. of Health and Mental Hygiene prior to b | DOWS a |
| HE JAN LE | has bee | n 23 s |
| CIAN: Th | artificate he State | or item |
| PHYSI | r this ce | arked, |
| TENDING | OR: Afte | B is m |
| AL OR ATTENDING PHYS | DIRECT hours a | item 2 |
| 10SPITAL | TO TAKE FUNERAL DIRECTOR; After this certif De filed within 72 hours after death with the | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the media |
| TO THE HOSPITAL | Flied w | WPORT |
| € | FIG | - |

| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last, | Willie | Barnes, Jr. | CAIE | OF DEATH | 2. DATE | REG. NO. | Y | | TIME OF DEATH |
|---------------|--|--|--------------------------------------|---------------|---------------------------------------|----------------|-----------------------------------|---------------|-----------------------|---|
| | 4. SOCIAL SECURITY NUMBER | lie | | arno | | rebr | uary . | | | 3:15 |
| | 254-30-9508 | 1 🔯 M 2 🗆 F | GE (In yrs. lest birthdey) 70 YRS. | IF UNDER 1 Y | EAR IF UNDER 24 HRS | (Month | DE BIRTH , Day, Year) -06-2 | | Country) | C • |
| OR | 9a. FACILITY NAME (If not institution, give Maryland General | | | | imore Cit | | | 9c. COUNT | Y OF DEATH | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUN | | 10c, CITY | TOWN OR I | | | | | | . INSIDE CITY |
| | MD. N/A | . | | Balti | more City | | | | | LIMITS? |
| FUNERAL | 100. STREET AND NUMBER 827 N. ARLING | TON AVE. | APT.702 | | 101. ZIP CODE 21217 | | | | USA | COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1.67. Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 | ER IN U.S. ARMED YES 2 NO DR DATES | If y | S DECENDENT OF NISI | ican, Puarto F | ? (Specify Yee lican, atc.) | or No— 1 | Black, Wh Specify: | |
| | 15. DECEDENT'S ED | | 16a. DECEDENT'S | | | 16b. | KIND OF BUS | INESS/INDUS | | BLACK |
| COMPLETED | (Specify only highest grace Elementary/Secondary (0-12) 12 | College (1-4 or 5+) | MECHAN | retired.) | ing most of working | U | NK | | | |
| | 17. FATHER'S NAME (FIREL MISSIN, LINE) BOP WOODEN | | | | 18. MOTHER'S ANNI | NAME (First, A | | Surneme) GARR | ETT | |
| TO BE | 186. INFORMANT'S NAME (Type/Print) GAIL BARNES | | | | RLINGTON | | | | | .MD.2 |
| | 20s_METHOD OF DISPOSITION 1 X Burtal 2 Cramation 3 Per 4 Donation 5 Dither (Specify) | moval from State | 20b. PLACE AND DATE OF | F DISPOSITION | | -15-9 | | CATION — CH | | Stata MD . |
| | 21. SIGNATURE OF PUNERAL BERVICE L | | | 22. NA | ME ANO ADDRESS OF | FACILITY | | | | |
| | 1/1/10 | They | | A1 63 | LBERT P. 38 N. GI | WYL1 LMOR | STRE | | PA 212 | 17 |
| CERTIFICATION | Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumon DUE TO (OR C. Pleurai DUE TO (OR | AS A CONSEQUENCE OF |): | | | | | | |
| MEDICAL | PART II. Other aignificant condition | one contributing to dee | ith but not resulting i | n the unde | rrying ceuse given | in Part i. | 24a. WAS AN PERFOR 1 YES 2 | MEO? | COM OF E | RE AUTOPSY FIND ILABLE PRIOR TO MPLETION OF CAL DEATH? |
| | DID TOBACCO USE CON | TRIBUTE TO CAUS | E OF DEATH YE | s 🗆 No | D UNCERT | AIN 📮 | | | ,,, | YES 2 NO |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | 28. PLACE OF DEAT | OTHER: | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 26a. DATE OF INJU | JRY 26b, TIM | OF 28 | g Nome 5 Reelden Bc. INJURY AT WORK? | | CRIBE HOW I | NJURY OCCU | JRED | |
| ВУ | X Neturel 5 Pending | 28a, PLACE OF IN | JURY — At home, farm, s (Specify) | | 1 YES 2 NO | | ATION (Street or Town, State) | | r Rural Route | Number, |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFYINO PHY | SICIAN: To the best of my | | | | | | | | |
| BE CON | 29b. SIONATURE AND TITLE OF CERTIF | NER: On the beele of exami | nation end/or investigation | n, in my opir | 29c. LICENSE | NUMBER | and place, an | 29d, DATE | SIGNED (Mor | nth, Day, Year) |
| 10 | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CAUSE O | F OEATH (ITEM 27) (Type, | Print) | 8924 | | | 1 | -11-9 | 26 |
| F | 30. NAME AND ADDRESS OF PERSON N Dr. Syed Hague C/C |) Maryland (| | pital | . * 82/ Li | nden A | venue | | | |
| _ | | | | | | | | | | |
| _ | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | • | | | | | | | |

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| 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumere) 18. Mother's | | | 1 Decedentia Nama (First 12 data 1 and | | Cer | tificate of | Death | | Reg. No. | | | |
|--|--|---------------------------------|---|-----------------------|-----------------------------------|---|---|----------------------------------|---------------------------------------|--|--|--|
| Countries Coun | Physic | ian | | | | | | Month | Dey | Year | | |
| 16.4.8 Marvick Ave. 16.4.8 January Link | | | | | | | | | | | | |
| Social Security Number Social Security Num | Examir | ner | | | | | | | | | | |
| 16-90-1997 12 is 2 F 33 yrs. Morthal Government Government Morth May 25,1962 MD MD ND ND ND ND ND ND | | | | | | M Hadas 4 Vasa | | | | | | |
| To See 100 County The See | | | 21.6-80-1997 1首称 20 | | | | | May 25 | , Year) 5,1962 | | | |
| Elementary/Secondary (0-12) College (1-for 5+) Maintenance McCormicks | Bud * | | | 10c, Cit | tv. Town or Loc | ation | | | | 10d Inside City I | | |
| Elementary/Secondary (0-12) College (1-for 5+) Maintenance McCormicks | e Maryli Sa-f sho | ctor | | | | | re | | | -100, | | |
| Elementary/Secondary (0-12) College (1-for 5+) Maintenance McCormicks | 4 2 2 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | - Sir | 10e. Street end Number | | | 10f. Zip Code | | | 10g. Citizen of W | /het Country? | | |
| Elementary/Secondary (0-12) College (1-for 5+) Maintenance McCormicks | 15 W | | 1648 Warwick Ave | · . | | 212 | 16 | | US | SA | | |
| Elementary/Secondary (0-12) College (1-for 5+) Maintenance McCormicks | 90 | 1 e | 11. Meritel Stetus 12. Was | Decedent Ever in U | I,S. 13. V | Ves Decedent of H | Ilspanic Orlgin? (Sp en. Mexican, Puerto | ecify Yes or No- | 14. Rece | | | |
| Elementary/Secondary (0-12) College (1-for 5+) Maintenance McCormicks | ors and | | Never Merried 2 Merried 1 H | Yes 2 No es, Give | | | | 11041, 010.) | | | | |
| 15. Mortier's Name (First, Modde, Last) 16. Mortier's Name (First, Modes, Cast) 16. Mortier's Name (First, M | "natura | | 15. Decedent's Education (Specify only highest grade compl | eted) | 16e. Deced | ent's Usuel Occup | petion during most of work | ing | 16b. Kind of Bu | siness/Industry | | |
| 15. Mortier's Name (First, Modde, Last) 16. Mortier's Name (First, Modes, Cast) 16. Mortier's Name (First, M | THE REAL PROPERTY. | Comp | | ege (1-4or 5+) | | | • | | McCor | micks | | |
| Part | of the state of th | Be (| | | | | 18. Mother's Nem | e (First, Middle, | Maiden Surneme | θ) | | |
| Part | Ment Went rked rice | 10 | Robert Broom | | | | Marsha | a Woode | en | | | |
| Part | and and | | 19e. Informent's Neme/Reletionship (Type, Prin | t) | 19b. Meilin | g Address (Street | and Number or Rur | al Route Numbe | r, City or Town, | Stete, Zip Code) | | |
| Security | | | Marsha Palmer | | | | | Balto. | , MD | 21216 | | |
| Second Composition Compo | | | | 20b. F | Plece of Dispos cemetery, crem | sition (Neme of etory or other ple | ce) | Dete | 20c. Location - | City or Town, Stete | | |
| 21. Signature of Funerel Service Licensee 22. Name and Address of Feelilly James A. Morton & Sons Funeral Home 1701 Laurens St. balto., Mp 21217 23a. Part. Ender the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate thick, for the state of the death inc. Part of the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate thick, for the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate thick, for the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate the mode of dying, such as cardiec or respiretory errest, Approximate th | IT o | | | Mt. | . Zior | Cemet | ery 2 | 2-15 | Balti | more, Mar | | |
| 23a. Part. Entir the disease, or complications that caused in each ine. Dark to cause on each line. Sequentially list conditions, terror to the cause of each ine. Dark to (or es e consequence of): Due to (or es e con | Departr importa any inj | | 21. Signal of Funerel Servica Licensee | 101-1- | Ja | ames A. | Morton | | | | | |
| Due to (or as a consequence of): | | 1701 Laurens St. balto., MD 212 | | | | | | | | | | |
| Per II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | siclan and bunal-transit | | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury c | Due to (c | or es e consequ | DEFICI | ENCY | VIRUS | | YEARS | | |
| Perf II. Other significant conditions contributing to death but not resulting in the underlying cause given in Perf I. 23b. Did tobacco use contribute to the cause of de 1 Yes 2 No 3 Probably 4 Unix Probably 4 Uni | 2 0 | | resulting in deeth) Lest | Due to (o | or as e consequ | uenca of): | | | | | | |
| 24e. Wes en eutopsy performed? 24e. Wes en eutopsy performed? 24e. Wes en eutopsy performed? 25e. Plece of Deeth (Check only one) 25e. Plece o | d for | icia | Pert II. Other elgoificant conditions contribution | to death but not res | sulting in the un | deriving cause on | ven in Pert I | 23h Did t | obacco uea con | tribute to the cause of d | | |
| 24b. Were eutopsy findle eveilable prior to completion of cause of deeth? 25c. Was case referred to medical examiner? 25c. Plece of Deeth (Check only one) 25d. Plece of Deeth (Check | ache ache | | Total State algerites and continue continuents | to death but not 143 | atting in the cir | derrying cause gr | voit iii i oit i. | | 11 | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | s been sign | | | | | | | 24e. Wes perfo | en eutopsy med? | eveilable prior to completion of caus | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | 0 - 6 | Ю | | | | | | 101 | es 2 No | 1 ☐ Yes 2 No | | |
| 27. Menner of Death 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Aresidence 6 Other (Specify) 27. Menner of Death 1 Neturel 2 Accident 3 Sulcide 4 Homicide 4 Homicide 28a. Dete of Injury M 28b. Time of Injury M 28c. Injury et Work? 1 Yes 2 No 28b. Pleca of Injury - At home, term, street, fectory, office 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 29a. Certifier Check only one) 29a. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and due to the cause(s) and menner as steted. 29b. Signeture end title artifier 29c. License number 29d. Date signed (Month, Dey, Year) | rtifica stor, | | | | | | 26. Piece of Deet | h (Check only o | ne) | | | |
| 2 Accident 3 Sulcide 4 Homicide 28e. Pleca of Injury - At home, term, street, fectory, office 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 29a. Certifier (Check only one) 29m. Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner as steted. 29b. Signeture end title 29b. Signeture end title 29c. License number 29d. Date signed (Month, Dey, Year) 29d. Date | neral direc | P | 1 ☐ Yes 2 No Hospital: 27. Menner of Death 28a. | Dete of Injury | 28b. Time of | 3LI DOA | 4 LI Nursing Ho | | | | | |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signeture end title (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29c. License number 29d. Date signed (Month, Dey, Year) | After Court. Director: A I in by the It | ertificati | 2 Accident Investigation 3 Sulcide 6 Could not be determined 28e. | | ome, term, stre | M 1 | Yes 2 No | | | er or Rural Route Number, | | |
| D33026 2/10/96 | 24 hours Funeral ately fills | | (Check only 2 Medical Examiner: On | the basis of examine | owledge, deeth | occurred at the tile estigation, in my o | me, date end placa, opinion, deeth occur | and due to the ored et the time, | cause(s) and med date end plece, e | nner as steted. and due to the ceuse(s) | | |
| | within To the | Me | , dit | 7 | _ \ | | | (_ | 29d. Date signed | (Month, Dey, Year) | | |
| 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) | | | | Des- | 1 Ma | 1) 12. | 720 C | 0 | -110 | 16 | | |
| | | | 30. Name end eddress of person who completed | 1. | | • | | | | | | |
| GREGORY THYLOR, M.D. 29 S. PALA ST., BAGTIMORE, MD ZIZO | Sta | ite | | 32. Registrario Signa | | | | | | | | |

DHMH 16 Rev 6/95

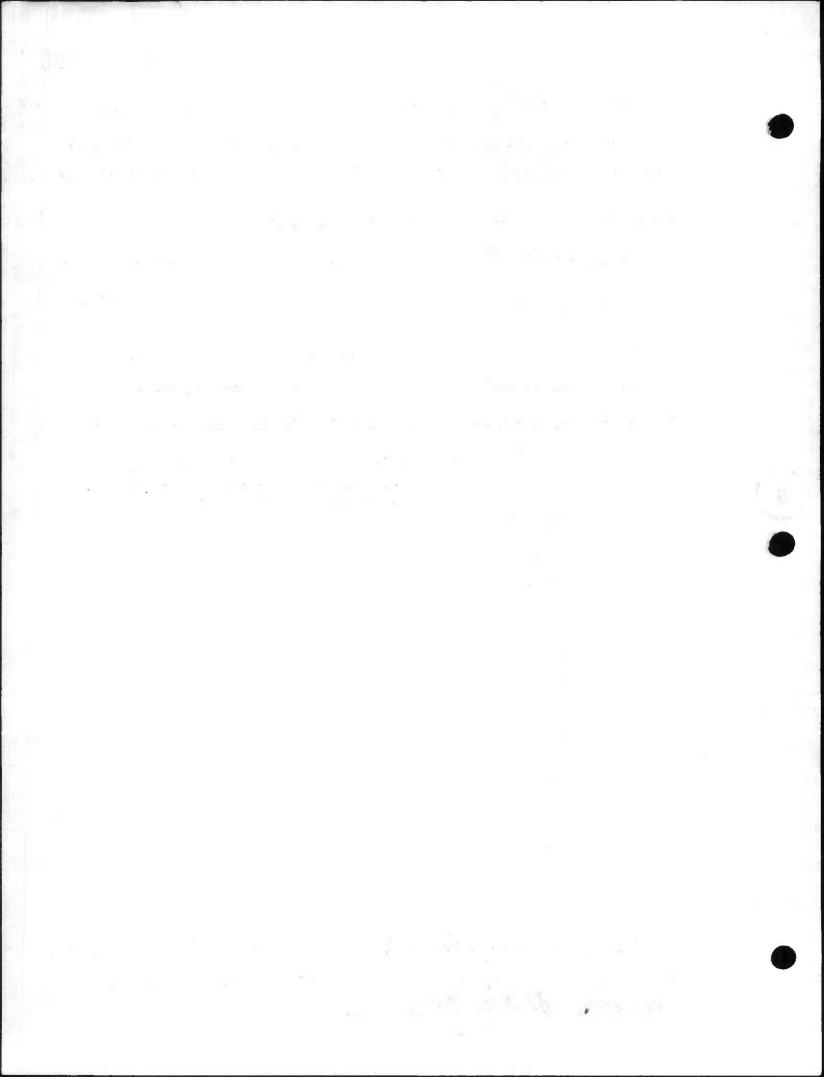
No. 11

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible

State of Maryland / Department of Health and Mental Hygiene 6 03523

| | | | otate of marylane | Certificate of | | | ng. No. | 13323 | |
|-------------|--|----------------|---|--|--|--|---|--|--|
| | Physic /Medi | | 1. Decedent's Neme (First, Middle, Last) HEUN W. CARRVTHER | 15 | | 2. Dete of Deeth Month | n Dey Yee | 3. Time of Death | |
| t | Exami | | 4a. Fecility Neme (If not institution, give street end number) | | 4b. City, Town, or Lo | cation of Deeth | 4c. County of De | eeth | |
| | Funeral Director | | North Arundel Hospital 5. Sociel Security Number 6. Sex 7. Age (In yrs. late 229-16-6042 $^{1\square M}$ $^{2\square F}$ 7 7 7 1 | | Glen Bur: If Under 24 Hrs. Hours Min. | nie 8. Dete of Birth (Month, Dev. 12/2) | Anne Ar year) 9.8 1924 No | rundel Hithplece (State or Foreign Country) Orth Caroli | |
| | ryland how Lat | | Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, | , Town or Location | | | | 10d. Inside City Limits | |
| | the Ma 28a-f s notified | Director | Maryland Baltimore Ba | altimore Hic | hlands | 16 | og. Citizen of What (| 1 ☐ Yes 2 📉 No | |
| 020 | us after death with the Maryla II", or lisms 23s or 25s-f show Earniner mant be notified at | by Funeral Di | 4132 Annapolis Road 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S Armed Forces? 1 Yes, Give Yes, Give Year or Detes: | 2122 | fispenic Origin? (Spe en, Mexican, Puerto I | | United | States nerican Indien, hlte, etc. | |
| 21215-0020 | within 72 hours at ene. then "naturel", or he Medicel Exem | Completed | 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 1 2 | 16a. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retired | | ng 1 | 16b. Kind of Busines | | |
| | The state of the s | Be Co | 17. Fether's Neme (First, Middle, Last) | wile i | 18. Mother's Neme | (First, Middle, N | Manufac Meiden Sumeme) | turer | |
| lan | feorita fead for ev | To B | Jessie B. Whitacker | | Elizal | beth S. | Dezern | | |
| Maryland | s man | | 19e. Informent's Neme/Relationship (Type, Print) | 19b. Melling Address (Street | end Number or Rura | l Route Number, | City or Town, Stete | , Zip Code) | |
| | and and m 27 In the tr | | Almeda Potaet Sister | 900 Dolphin | | - | | | |
| more | Pages 1 ment of H ant: if the ury or off | | Taybunar 2 Defemetion 3 Premover from State | ece of Disposition (Name of matery, cremetory or other pleadowride Mem | | | orsey, | or Town, Stete Maryland | |
| Ball | Depart Import any in | | 21. Signeture of Funerel Service Licensee | 22. Name end Addre Ambrose 2719 Ham | Funeral | | | owne 1227 | |
| Į | Physician | | 23a. P. r.f. Enter the disease, or complications that caused the deeth. hock, or heart feilure. List only one cause on each line. | Do not enter the mode of dylr | ng, such es cardiec o | r respiretory erre | st, | Approximete tnterval Between Onset and Deeth | |
| P | /Medical Examiner | | tmmediate Cause (Final disease or condition resulting In death) | | L INF | FAMCTT | on | 8 Drys | |
| _ | nsit | Examiner | b. REVAL | es e consequence of): FAILUN 8 | - | | | 14esa | |
| 60, | ificate be executed g physician and as the buriel-transit | al Exar | H and landon to be a district of | es e consequence of): LHAT | FAILUR | e | | 14RAR | |
| x 68760, | 5 O 6 | Medical | resulting in death) Lest | | | | | | |
| Box | attenc for us | clan | | | | | | 1 year | |
| P.O. | requires that the death cer been signed by the attendir should be detached for use | y Physician/N | Pert II. Other significant conditions contributing to death but not result | ting in the underlying cause give | ven in Pert I. | | | Probably 4 Unknown | |
| Records, | The lew requires that the death cer ate hes been signed by the attendin page 2 should be detached for use | Completed by | | | | 24e. Wes en | | b. Were autopsy findings available prior to completion of cause of death? | |
| al Re | sician: The lew certificate hes t irector, page 2 s | | | | | 1 □ Ye | s 2 No | 1 □ Yes 2 No | |
| Vital | sician certifi irecto | o Be | 25. Wes case referred to medical examiner? 1 Yes 22 No Hospitel: Inpatient 2 F | Oth | 28. Place of Deeth | | | | |
| on of | Attending Physician: or death. ector: After this certific by the funeral director, | | 27. Menner of Deeth VNeturel 5 □ Pending 28e. Date of Injury (Month, Dey Year) 2 | 28b. Time of linjury 28c. Injury Wor | y et rk? | | nce 8 Other (S) w Injury occurred | Decify) | |
| Division of | 교육교 | Certification: | 2 Accident 3 Sulcide 4 Homicide Investigation 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify) | me, ferm, street, fectory, office | | 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) | | | |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in its | edical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl one one of memory stellar. To the basis of examinetic end menner stellar. | ledge, death occurred et the tir on end/or Investigetion, in my o | me, dete end plece, e | nd due to the ca | use(s) and menner ite end plece, and d | es steted. lue to the cause(s) | |
| | Within To the | Me | 29b. Signature and title of certifier | 29c. Licens | | | d. Dete signed (Mo | | |
| | | | 30 Neme and eddress of person who completed cause of deeth (Item 2 | M) D2 23e) (Type, Print) 301 (405) PITAL | 8221 | F | ebuny ! | 9, 1996 | |
| | | | DAN H SCHME (Menth Day York) | 301/tospiral | Drive, C | LENBU | NIE,M | ANYLAND | |
| | Sta Registr | | 31. Date filed (Month, Day Yeer) FEB 1 3 1996 Guha Turidism | 4 | | | | 41041 | |

DHMH 16 Rev 6/95



| . DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho hours after death with the State Debt, or Health and Mernal Hypiens prior to burial, cremation, or removal. | |
|--|---|---------------------------------|
| TO THE HOSPITAL OR ATTENDING PHY | TO THE HUNERAL DIRECTOR. After this he | IMPORTANT: It item 28 is marked |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH Francis 1996 John CONTINO February 09, 3:00 рм 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) Dec. 20, 1934 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 X M 2 - F HOURS 216-30-0446 61 Maryland YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Franklin Square Hospital DIRECTOR Rossville Baltimore 10a. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Baltimore Edgemere Maryland 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? United States 21219 7228 River Drive Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 XX Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 XNO Specify Specify: BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years Surveyor Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname, John Joseph Contino Lillian Nettie Hoffman BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Eva V. Contino 7228 River Drive Road Edgemere, Maryland 21219 209 METHOD OF DISPOSITION
1 Disposition 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Lawn Cemetery 2/12/1996 4 Donation 5 Other (Specify) Baltimore, Maruland 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dear 4 and 7922 Wise Ave. Dundalk, Maryland 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximata** interval Between shock, or heart failure. Liet only one cause on each line Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) 7 days Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Hepatic Coma
DUE TO (OR AS A CONSEQUENCE OF): 7 days CERTIFICATION Sequentially list conditiona, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reauiting in desth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Renal Failure, Cirrhosis, myocardial infarction 1 TES 2 NO DF DEATH? Pulmonary Edema 1 YES 2 NO PHYSICIAN:

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🖾 UNCERTAIN 🗆

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one

HOSPITAL:
1 Appetient 2 ER/Outpetient 3 DOA 1 YES 2 X NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 1 X Natural 5 Pending investigation 2 Accident

8 Could not be

OTHER: 4 Nursing Home 5 Residence 8 Other (Specify, 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

1 YES 2 NO 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER

(Chance Annie)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.

2 __ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Carol Richardson

29c. LICENSE NUMBER 4630 29d, DATE SIGNED (Month, Day, Year, February 9,1996

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Carol Richardson, M.D. 9000 Franklin Square Drive Baltimore, MD 31. DATE FILED (Month, Day, Year)

32 REGISTRAR'S SIGNATURE FEB1 3 1996

BY

COMPLETED

BE

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3 Suicide

4 Homicide

(Check only one)

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| | 1 - FOR STATE REGISTRAR | STATE OF N | | | | | HEALTH AND | MENTA | L HYGIEN REG. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 1 | | | OF DEATH | | 3 | TIME OF DEATH | 0 |
| 8 | Rose | | | | - | CA | ARR | FE P | RUARY | | YEAR 1960 | 1916 | N |
| 3 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | t birthday) | | R 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | O. BIRTHPL | ACE (State or Foreig | gn |
| ĺ | 212-16-4497 | 1 M 2 💢 F | 74 | YRS. | MONTHS | DAYS | HOURS MIN. | Marc | ch13, | 1921 | Mar | yland | |
| | 9e. FACILITY NAME (If not institution, give s | | | _ | | | OR LOCATION OF DE | EATH | | | TY OF DEA | | |
| DIRECTOR | PENINSULA REGION | AL MEDICA | AL CENTE | R | | SALI | SBURY | | | MI | COMIC | 0 | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | | | | | | | | | | |
| <u>R</u> | 102.00011 | I | | | Y, TOWN | | | | | | 10 | Dd. INSIDE CITY LIMITS? | |
| | Delaware 10e. STREET AND NUMBER | | | Se | lby | | | | | | 1 | YES 27 NO |) |
| FUNERAL | | | | | | 10 | of. ZIP CODE | | | 10g. CiTti | ZEN OF WHA | AT COUNTRY? | |
| Ä | 133 Shady Park | | | | | | 19975 | | | Uni | ted : | States | |
| E | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | MED | 13. | | CENDENT OF HISPAN | | | or No- | 14. RACE - | American Indian, | |
| ВУ | 3 Widowed 4 Divorced | IF YES, OIVE W | | | | | S 2 NO Specif | | nicari, etc.) | | Spanific | | |
| | 15. DECEDENT'S FOU | | | | | | | | | | | white | |
| 1 | (Specify only highest grade | | (G | CEDENT'S | work done | durina m | ON ost of working | 166 | . KIND OF BUS | SINESS/IND | USTRY | | |
| ٣ | Elementary/Secondary (0-12) | College (1-4 or 5 + | •) | Do NOT us | | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | nome | mak | er | · · · · · · · · · · · · · · · · · · · | | own l | | | | |
| | | | | | | | 18. MOTHER'S NA | | | , | | | |
| BE | Donoto Denision (1900, INFORMANT'S NAME (Type/Print) |) | | | | | Carme | | | | | | |
| 2 | | | | | | | and Number or Rural i | | | | | | |
| | Wadsworth Carr 200. METHOD OF DISPOSITION | , husba | | | | | ark Sel | | | | | | |
| | 1 XBuriel 2 Cremetion 3 Rem | oval from State | 20b. PLACE A cemetery, gre | matory or o | OF DISPO | SITION (N | | DAT | | | Olty or Town | | |
| | 4 Donation 8 Other (Specify) | | wood] | awn | | | | | Woo | odla | wn, l | Marylan | 1d |
| | 21. SIGNATURE OF PUNEFAL BERVICE DO | Engles . | | 1 | A | mbr | OSE Fun | cury era1 | Home | e. Ti | nc. | Arbutu | 15 |
| | 1600 | K | - | -7× | | | Sulphu | | | | | 21227 | |
| | 23. PART I. Enter the diseases, or o | complications that | t ceused the de | ath. Do r | | | | | | | | Approximata | |
| | ahock, or heart failure. IMMEDIATE CAUSE (Final | List only one cau | se on each line | | | | | | | | | interval Betw Onset and D | veen |
| | disease or condition | Record | Jan. F | -mila | 100 | | | | | | | Onset and Di | -atri |
| | resulting in death) | RESPIRE | OR AS A CONSEC | DUENCE OF | F): | | | | | | | | |
| - | - Complication of Stroke | | | | | | | | | | | | |
| 0 | Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING | | | | | | | | | | | | |
| Ē | CAUSE (Disease or Injury that initiated events | DUE TO | OR AS A CONSEC | DUENCE OF | F): | | | | | | | | |
| E | reaulting in death) LAST | d | | | | | | | | | | | |
| Ö | DART II Other significant and disc | | 4-14-1-1 | | | | | | | | 1 | | |
| MEDICAL | PART II. Other aignificant condition | contributing to | | | | | g ceuse given in | | 24s. WAS AN. PERFOR | | | ERE AUTOPSY FINDS AILABLE PRIOR TO | NGS |
| ă | - Trystandial 3 | 7.474 | | | 79 | | | emù | 1 YES 2 | NO | | MPLETION OF CAUS DEATH? | 3E |
| | Bacteremia. | Kidne | | | (5-1 | - 15 | heding | | | | 1 | YES 2 NO | |
| PHYSICIAN: | DID TOBACCO USE CONTI | RIBUTE TO CA | USE OF DEA | TH YE | S 🗆 | NO [| UNCERTAIN | N | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | E OF DEAT | | - | | | | | | | |
| 1S | 1 TYES 2 NO | 1 Inpetient 2 | ER/Outpatient 3 | □ DOA | OTHE | | ne 5 🗆 Residence | 6 🗆 Other | (Specify) | | | | |
| H | 27. MANNER OF DEATH | 26e. DATE OF (Month, Di | | 26b. TIM | E OF URY | 28c. IN. | JURY AT | 28d. DE\$ | CRIBE HOW IF | NJURY OCC | URED | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | ,,, | | М | | YES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE Of | F INJURY — At hor | me, farm, s | treet, fec | tory, offic | 10 | | ATION (Street a | nd Number | or Rural Rout | n Number, | |
| | 4 Homicide detarmined | | oral (apoutly) | | | | | City | or Town, State) | | | | |
| PE | 290. CERTIFIER 1 CERTIFYING PHYSI | | | | | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. | | | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | _ | | | 29c. LICENSE NUN | | | | | | |
| H | 290. SIGNATURE AND TITLE OF CENTIFIER 290. LICENSE NUMBER 290. DATE SIGNED (Month). 200. 11. 9 | | | | | | | | | | | | |
| 2 | 30 NAME AND ADDRESS OF PERSON WH | COMPLETED ONLY | we re | A 000 100 | 24 | | 7 14 | 0 67 | | - 4 | 11 | . 1.6 | |

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

106 M ILFO NO

32. REGISTRAR'S SIGNATURE a Davidson Rando

57.

HIOY

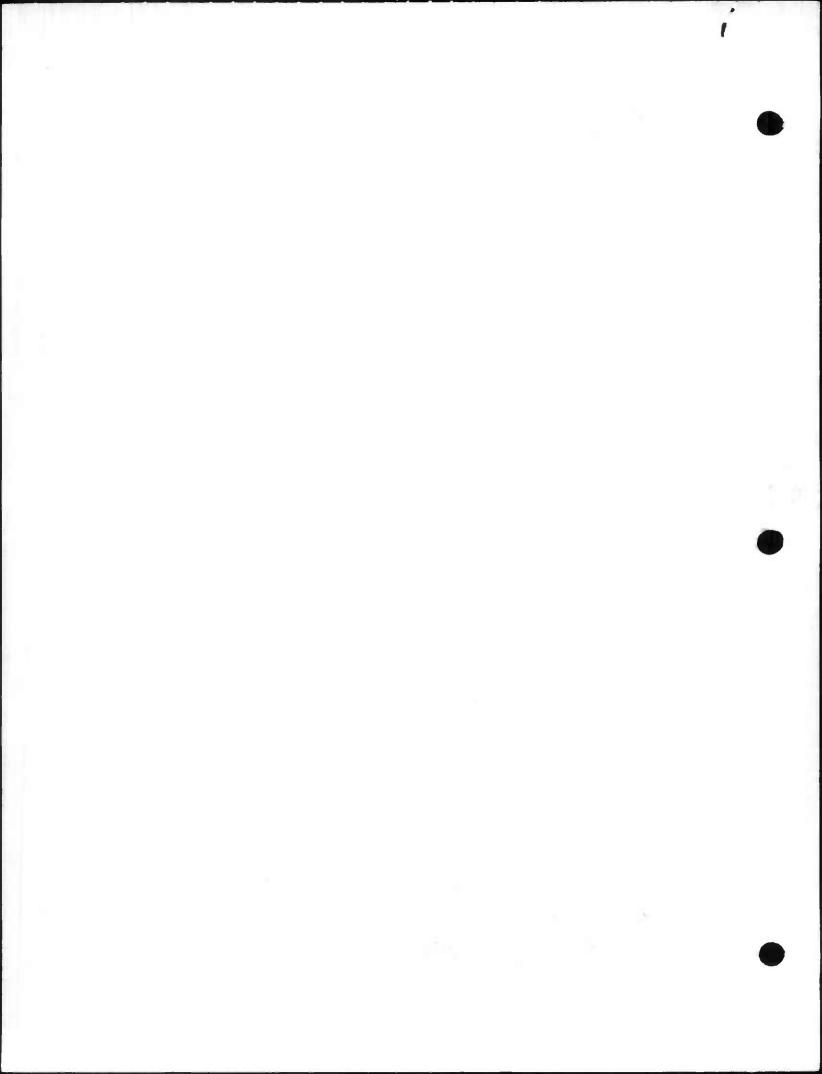
INDERETIVA

31. DATE FILED (Month, Day, Year) FEB 1 3 1996

30. NAME AND

DHMH-16 Rev 1/89

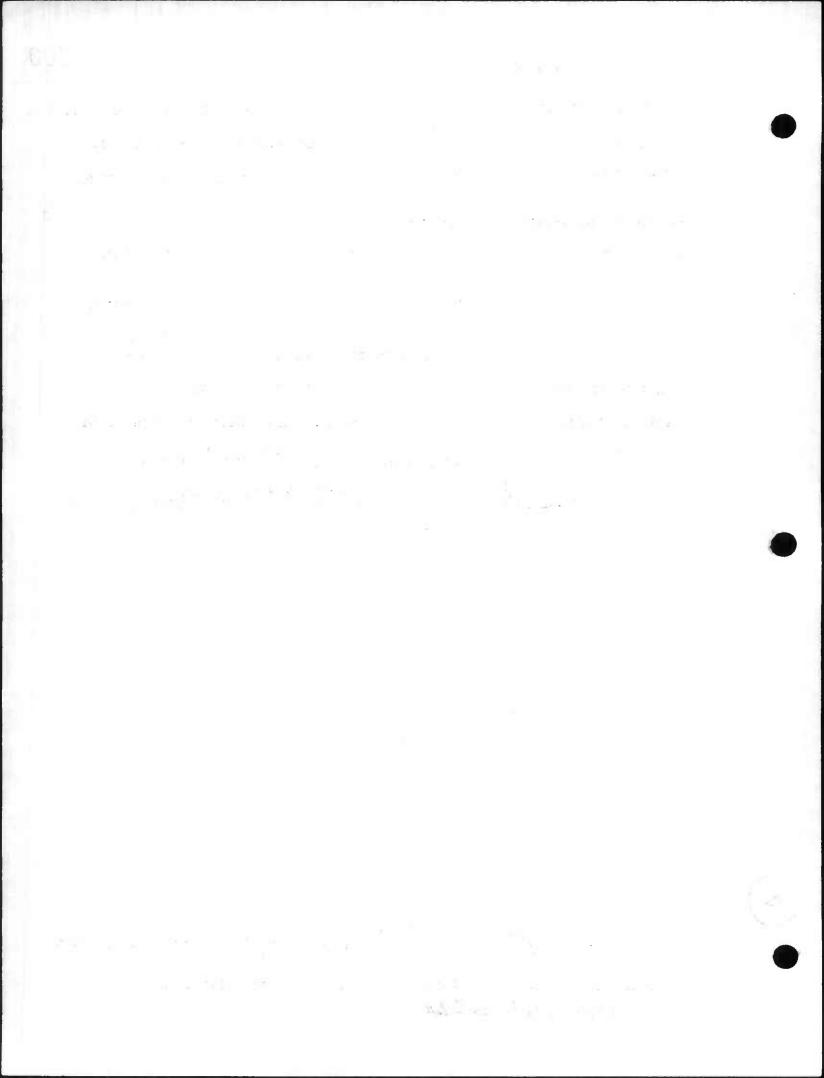
SALISBURY



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

| | | F | ilmg, 733, item #19a, . | 3/2//%,cyw,] | per th | Cer | tificate d | of Death |) | | Reg. No. | 20 | 00 | 0 2 0 |
|---------------------|---|--------------------|--|--|------------------------|--------------------------|---|------------------------------------|-----------------------------|---------------------------------------|-----------------------------------|-------------------------------------|---|-----------------------------------|
| B | Dhuais | | 1. Decedent's Name (First, Middle, Las. | t) | | | | | | 2. Data of D | eath | Vaar | 3. Tim | a of Death |
| J | Physic /Medi | | DAVID M. CRABTI | REE | | | | | F | EBRUA | RY 10, 1 | Yaar 1996 | 6:30 | A.M. |
| | Exami | | 4a. Facility Name (If not institution, give | street and number) | | | | 4b. City, T | own, or Loc | ation of Dea | th 4c. Count | y of Death | 1 | |
| | | | 408 BAYLOR RD. | | | | | | BURN | Œ | ANNE A | ARUND | EL | |
| | Funeral Director | | 5. Social Security Number 6. Se 229-09-6206 | ox 7. Age (M 2□ F | In yrs. last i | birthday) Yrs. | If Under 1 Y | | | 8. Data of Bi (Month, D FEB .] | rth ay, Year) 4,1918 | | nplace (Sta intry) GINIA | ta or Foraign |
| | show a st | | 10a. Stata 10b. County | 1 | Oc. City, To | own or Loc | cation | | - | | | 1 | 10d. tnaid | e City Limits |
| | Mar | tor | MARYLAND ANNE ARUI | NDEL | GLEN E | BURNI | E | | | | | | 1 🗆 Y | res 2 No |
| | h with the Me 23a or 28a-f | ai Director | 10e. Street and Number 408 BAYLOR RD. | | | | 10f. Zip Coo 2106 | | | | 10g. Citizen of UNITED | | | |
| 020 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth end Mental Hygiene. If Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exposper court be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ev Armed Forcas? 1 ☑ Yes 2 ☐ No It Yas, Giva Yaar or Dates: | erin U,S. WW II | | Vas Decedent Yas, specify (☐ Yes 2 🖾 | | | cify Yas or N lican, atc.) | | ce - Amari ack, Whita fy: WHI | | l. |
| 5-0 | 72 hours "natural", | Completed | 15. Dacedant's Edu (Specify only highest grad | | 18 | a. Deced | ent's Usual Oc | cupation | st of workin | ia. | 16b. Kind of E | Businass/I | nduatry | |
| 121 | rithin ne. | mpie | Elementary/Secondary (0-12) | College (1-4or 5+) | | | kind of work do OO NOT use re | 200 | | 9 | ARMY C | | OF | |
| 12 | Hygier there the | | 17 Fethada Nama (Finat Middle Local) | 4 | E | LECTI | RICAL E | | | affil a sala sa | ENGINE | | | |
| Maryland 21215-0020 | 2 should be filed within end Mental Hygiene. Is marked other than aurratic event, the Manatic event | To Be | 17. Fathar's Nama (First, Middla, Last) DAVID M. CRABTREE | 2 | | | | | | . MULI | JINS | ma) | | |
| | and 2 shaelth end n 27 is m | | 19a Informant's Name/Ralationship (T) | ype, Print) | 1 | | | | | | MARYLAN | | | |
| Baltimore, | permit. Peges 1 and 2 Department of Heelth e Important: If Item 27 Is any Injury or other trai | | 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) |) | cema | tary, crem | sition (Name o satory or other MATORY | place) F | | RY 11 996 | 20c. Location | | | |
| Ball | Depart Import any In | | 21. Signature of Funeral Service Licens | | | KI | Name and Ac RKLEY- 1 CRAI | RUDDICE | FUNI | | OME N BURNII | E, MD | 2106 | 51 |
| | | | 23a. Part1. Enter the disease, or composhock, or heart tailure. List only o | lications that caused the | e death. D | | | | | - | | - | Approxim | |
| | Physician /Medical Examiner | ner | Immediate Cause (Final disease or condition resulting in death) | a. 6/3 | ie to (or as | a conseque |) | cane | - | | | | Onset a | nd Death Neek |
| Box 68760, | that the death certificate be associted ed by the ettending physicien and detached for use as the burial-transit | n/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | с | e to (or as | · | | | | | | | | |
| | death cer e ettendir d for use | cia | Part It. Other significant conditions con | ntributing to death but r | not regulting | In the un | dochdog oauer | cives la Bert | I | 23h Did | tobacco use co | antelbute (| to the cau | ee of death' |
| P.O. | that the dended by the e | y Physician/ | Tark. Otto agrinoant conductie co | minoding to death but | TOUT TO SELECTION | , in the dir | denying cause | given in Part | 1. | | 49 | | | Unknow |
| of Vital Records, | aw requires is been sign 2 should be | Completed by | | | | | | | | | s an autopsy ormed? | a C | Vera autop valiable pri ompletion f death? | sy findings ior to of cause |
| = | E Se | Cou | | | | | | | | 10 | Yes 21 No | 1 | ☐ Yes 2 | Z NO |
| /ita | ysician: The s certificate director, per | Be | 25. Was case referred to medical examiner? | | | | | | e of Death | (Check only | one) | | | |
| of | Physician: this certific rai director, | 2 | 1 148 ZEJ NO | Hospital: 1 Inpatient | | | 3LI DON | | ursing Hom | | idence 8 □Ot | | ify) | |
| Dyvision | Attending P r death. ector: After by the funen | Certification: | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Y | ear) 28b | . Time of Injury | | njuryat Work? I∐ Yes 2⊡ | | 8d. Describe | how Injury occu | rred | | |
| 200 | pitalor Am eral Direct filled in by | Certifi | 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury building, etc. (| - At home, Specify) | farm, stre | et, tactory, off | ce | 2 | | (Street and Num wn, Stata) | ber or Rui | al Route N | lumber, |
| 0 | To the Hospi within 21 To To the Funer completely fill | edical | 29a. Certifier 1 | sician: To the best of n ner: On the basis of ex and manner stated | amination a | ge, death and/or inve | occurred at the | e time, date ar ny opinion, dec | nd place, as eth occurre | nd due to the d at the time | cause(s) and m date and place, | anner as : , and due ! | stated. to the caus | e(s) |
| | To with To the Comp | × | 29b. Signature and title of certifier | 1 | 5 | | 29c. Lic | ense number | Po | 7 | 29d. Data signe FEBRUAL | | | |
| | 600 | | 30. Name and address of person who concerns the concerns of th | 1 1 | | | | E 306, | GLEN | BURNI | E, MARYI | LAND | 2106: | L |
| | Sta Registr | te ar | FEB 1 3 1996 | 82. Registrar | Biggs tuy | | | | | | | ~ | | |



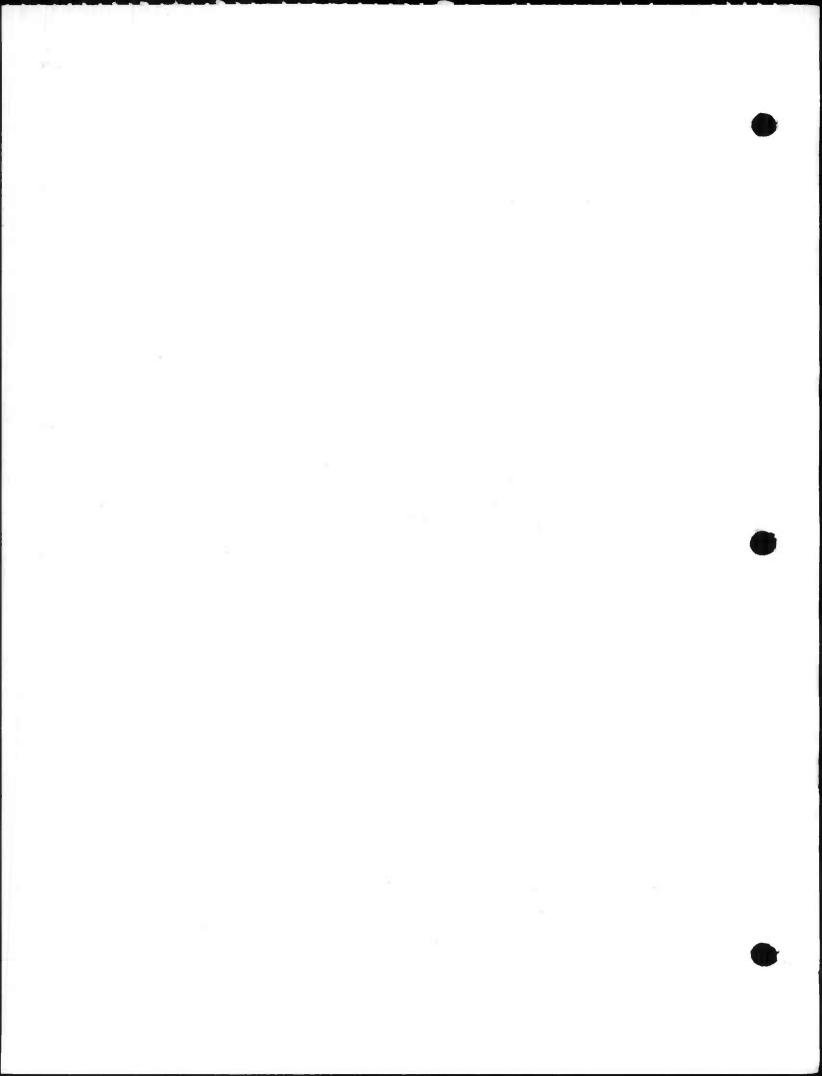
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| BALTIMORE, MARYLAND 21215-0020 | ler death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1.2.3 should | yal. | si examiner must be notified at once. | |
|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE FLOSTIAL OF ALTENDING PHYSICIAN: The law requires that me deam certificate be executed within after death. Page 5 may be retained by the hospital or attending physician. TO HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Planes 1 2 3 should | be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. | IMPUNIANT. IN 1981 26 IS MARKED, OF HEM 23 SHOWS BIY INJUTY, OF OTHER TRAINFAILE EVENT, THE MEDICAL EXAMINER MUST BE NOTIFIED AT ONCO. | TO RE COMPLETED BY DHYSICIAN: MEDICAL DEDTICIONALION |

| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|---|----------|
| R | CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE OF STATE OF | MARYLAN | ID / DEPAR | RTMENT O | F HEALTH / | AND ME | NTAL HYGIEN | | | | | | |
|--------------------|--|--|------------------------------------|---|---|--------------|---|------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | William H. Co | ollins | 2 | | | - 1 | | 1996 YE | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | | rrs. last birthday) | IF UNDER 1 Y | AR IF UNDER 2 | 4 HRS. 7. | DATE OF BIRTH | I a B | IRTHPLACE (State or Foreign | | | | |
| | 220-30-6770 1 1 M 2 1 F 9e. FACILITY NAME (If not institution, give street end number) | | O YRS. | | NOURS NOURS | MIN. AL | 19. 17,19 | irqinia | | | | | |
| TOR | Franklin Woods- Meridan | | | | WN OR LOCATION ROSSVI1 | | | 9c. COUNTY (| ltimore | | | | |
| FUNERAL DIRECTOR | 100. STATE 10b. COUNTY Md. Baltime | re | 10c. CIT | Y, TOWN OR I | ocation Middle | Rive | er | | 10d. INSIDE CITY LIMITS? | | | | |
| Ţ | 10e. STREET ANO NUMBER | | | | 101. ZIP CODE | _ | | I to- CITIZEN | 1 ☐ YES 2 ₹ NO OF WHAT COUNTRY? | | | | |
| NER/ | 12 Helicopter Drive | | | | 2 | 21220 | | US | | | | | |
| В | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDIFORCES? IF YES, GIVE | ENT EVER IN U. 1 YES 2 WAR OR DATE | 2 NO | If ye | DECENDENT OF a, specify Cuben, YES 2 NO | Mexican, P | ORIGIN? (Specify Ye verto Ricen, etc.) | | RACE — American Indian, Black, White, etc. Specify: White | | | | |
| ED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | :16 | a. DECEDENT'S | USUAL OCCU | PATION | | 16b. KIND OF BU | SINESS/INDUSTR | | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 10th | 5+) | IIIe. Do NOT u | work done durii se retired.) nter | g most of working | | | n/a | | | | | |
| 8 | 17, FATHER'S NAME (First, Middle, Last) | | | | 18 MOTHE | FR'S NAME | (First, Middle, Malden | Cumpmel | | | | | |
| | Benjamin E. Collins | | | | 101 1101 | | rie M. Cl | | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (S) | reet and Number o | | Number, City or Tox | | 1 | | | | |
| 임 | William Collins | | 1 | | | | | | Md. 21220 | | | | |
| | 20e. METHOD OF DISPOSITION | 20b. PL | ACEANDDATE | | | DII | | CATION — City of | | | | | |
| | 1 🔀 Buriel 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) | Cemeter | ry cremetory or claney | viher place) Vall | ev | 2 | | | ore Md. | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 1 2 4 | / | - | E AND ADDRESS | | | | | | | | |
| | R. Terry (o. | m 4 0 | 1/11 | | | | neral H | | Essex Md. 21221 | | | | |
| CERTIFICATION | 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line: IMMEDIATE CAUSE (Final disease or condition resulting in death) Approximate interval Batween Onest and Death Cause or condition a. METASTATIC RECTAL CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | | |
| ਹੋ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. | PLACE OF DEA | TH (Check only | one) | | | | | | | | |
| ZS | 1 ☐ YES 2 ☐ 1 ☐ Inpetient 2 | | nt 3 🗆 DOA | | Home 5 🗆 Reel | dence 8 | Other (Specify) | | | | | | |
| ВУ РН | 27. MANNER OF BEATH 1 Netural 5 Pending 2 Accident Investigation | F INJURY Day, Year) | 28b. TIM | JURY | INJURY AT WORK? | | d. DEŞCRIBE HOW | NJURY OCCURE | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | OF INJURY — (), etc. (Specify) | At home, ferm, | street, factory, | office | 28 | 1. LOCATION (Street City or Town, State) | end Number or Ru | ral Route Number, | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of MEDICAL EXAMINER: On the basic of | of my knowledg | e, death occurred/or investigation | ed at the time, on, in my opini | date end place, e | and due to 1 | he ceuse(e) end me | nner ee stated. | se(e) end menner se stated. | | | | |
| H B | 296. SIGNATURE AND TITLE OF CERTIFIER COLOR Reha | don | _ ms | | | SE NUMBER | | 29d. DATE SIGN | NED (Month, Day, Your) Navy 12, 1996 | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CA 9000 Franklin Square D | USE OF DEATH | Balt | Print) CI | MOL B | ICHA | 21237 | 9 | | | | | |
| | | AR'S ANATU | | | | | 01001 | | | | | | |



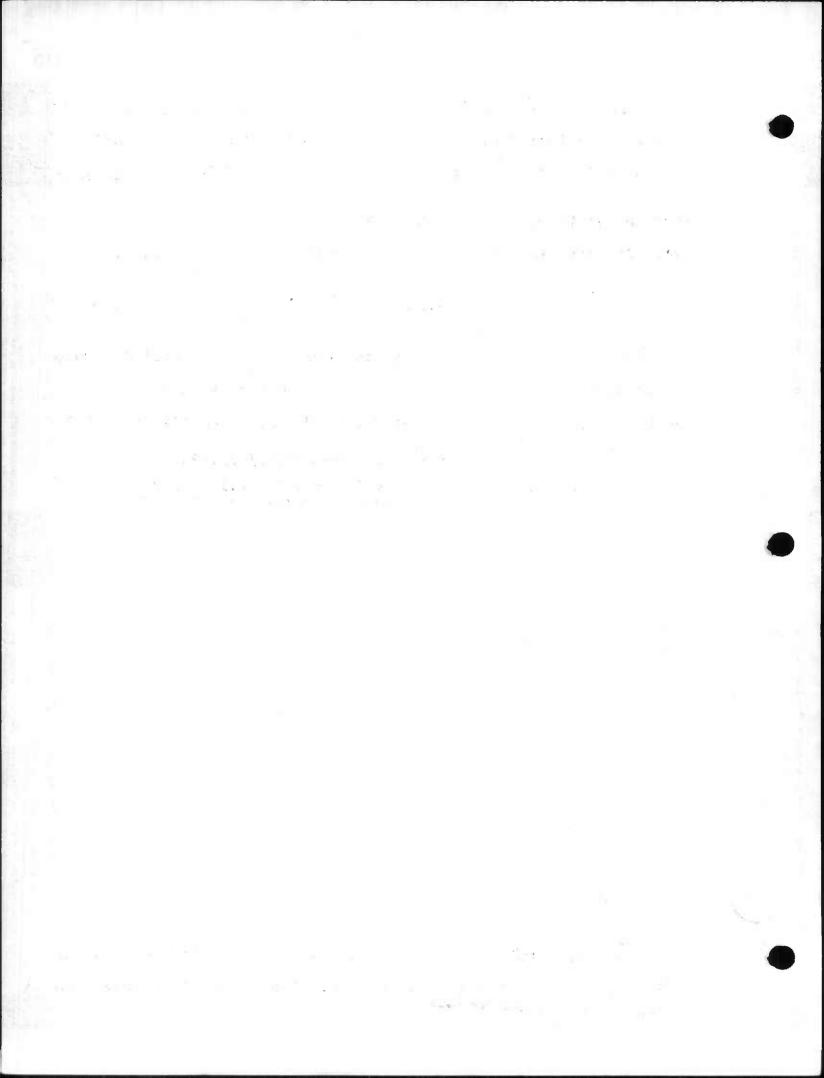
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State of Maryland / Department of Health and Mental Hygiene 96 03528

| | | | | Certific | cate of | Death | B | eg. No. | | | | |
|---|--|--|---|---|--|--|---|--|--|---|--|--|
| | | 1. Decedant'a Nama (First, Middla, L | | | | | 2. Data of Dea | th | | 3. Tima of Deat | | |
| Physicia /Medic | | James | J Cap | | | | Month February | Day | 1996 | 2046 | | |
| Examin | | 4a. Facility Nama (If not institution, gi | iva street and number) | | | 4b. City, Town, or | Location of Death | 1 | ty of Death | 70 14 | | |
| | | Bayview Medic | cal Center | | | Baltim | ore | | N/2 | A | | |
| Funeral Director | | | Sax 7. Aga (In yrs. 1120 M 2□ F 60 | last birthday) If U Yrs. Mon | nder 1 Yaar ths Days | | | Year) | | laca (Stata or Fore try) yland | | |
| 2 | - | Usual Rasidance of Decedant | | | | | | | | | | |
| tahow | | 10a. Stata 10b. County | | ty, Town or Location | | | | | 1 | 0d. Inside City Lim | | |
| 1 | 응 | Maryland Baltin | nore | Dundalk | | | | | | 1 □ Yas 2 🗙 | | |
| nial hydene. do other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at | Funeral Director | 10e. Street and Number 7401 St.Patric | cia Court | | | 222 | 0g. Citizen of U.S | | itry? | | | |
| E5 | ner | 11. Marital Status | 12. Was Decedent Evar In U Armed Forcas? | ,S. 13. Was D | ecedent of I | Hispanic Origin? (| Specify Yas or No- rto Rican, atc.) | | ce - Amaric | | | |
| al', or its | ρ | 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 1 GYas 2 No If Yes, Giva Yaar or Datas: 1958 | 100 | apecity Cub | | no Alcan, alc.) | Spec | ack, Whita, i Whi | | | |
| Seal | Completed | 15. Decedant's E | Education | 16a. Decedant's | Usual Occup | pation | -4/ | 16b. Kind of | | | | |
| - 4 | ed l | (Specify only highast gi | Collaga (1-4or 5+) | lifa. DO NO | T work dona OT usa retire | during most of word) | orking | | | | | |
| nd Mental Hygiene. marked other than imatic event, the M | 5 | 10 | | Truc | k Dr | iver | | Fuel | Oil | Compan | | |
| d other | Be | 17. Fathar's Nama (First, Middla, Las | t) | | | 18. Mothar's Na | ama (First, Middla, I | Maidan Suma | ıma) | | | |
| Aent rked tic e | To | Frank Cap | | | | Joseph | ine Kre | cek | | | | |
| | | 19a. tntormant's Name/Ralationship | (Type, Pnint) | 19b. Mailing Add | Irass (Street | and Number or F | ural Routa Number | , City or Town | n, Stata, Zip | Code) | | |
| 1 - 2 0 | | Joan P. Cap | | | | | t. Dund | | | | | |
| Heelth tem 27 other tr | | 20a. Mathod of Disposition | 20b. (| Place of Disposition | (Nama of | | Data | 20c. Location | - City or To | wn, Stata | | |
| Part V | | 1 Buriai 2 Tramation 3 Donation 5 Other (Special | ify) Gre | comatary, cramatory eenmount | Crem | atory 2 | | | | re | | |
| Departu Importu any Inju | | 21. Signature of Funeral Service Lice | 2 - L | | | | eral Ho | | | 21221 | | |
| | \neg | 23a. Part 1. Enter the disease, or con shock, or heart failure. List only | np cations that caused the deat | | | | | | | Approximata Interval Between | | |
| hysician | | | | | | | | | | Onsat and Death | | |
| /Medical | | Immediate Cause (Final disease or condition | 59. | Jamous | cell | 1.100 | cancer | | | Two Year | | |
| xaminer | | rasulting in death) | a. Due to (| 1011 | CANCO | | | 7100 1010 | | | | |
| 1 | ě | | | A MANAGE CO. | 017. | | | | | 1 -1-11 | | |
| b ansit | Examiner | Consessing the line and distance | U. | PS > S or as a consequence | ot): | | | | 1 | 1 dey | | |
| n an iel-tr | Exa | | - | | ot). | | | | | 1 Jack | | |
| sicle bur | | | c. Empyema Due to (or as a consequence of): | | | | | | | 1 week | | |
| nding physicien and use es the buriel-transit | Medical | rasulting in death) Last | d. Squemous cell lung concer | | | | | | | | | |
| attend for us | Slan | | - | | | , | | | i | | | |
| he at | Phy | Part il. Other significant conditions | contributing to death but not ras | ulting in the underlyi | ng ceusa gir | van in Part I. | 23b. Did to | bacco use c | ontribute to | the cause of dea | | |
| at be | | | | | | | 19(Y | es 2 No | 3 Prot | oably 4 Unkne | | |
| d by the | | | by | | | | | | | | | |
| igned by the | 0 | | | | | | | n sutoney | | ara autopsy finding allabla prior to | | |
| sen signed by the | ted b | | | | | | 24a. Was a perform | | 41. | andbid prior to | | |
| as been signed by the 2 should be deteched | pieted b | | | | | | | | COL | mpletion of ceuse death? | | |
| ta has been signed by the page 2 should be deteched | ompieted b | | | | | | | med? | of | mpletion of ceuse death? | | |
| ata has been signer page 2 should be d | e Completed | 25. Was casa retarred to medical | | | | 26 Place of De | perform | ned? | of | mpletion of ceuse | | |
| | o Be Completed | axaminer? | Hospital: 10 Innetient 2 | EB/Outnationt 3 | DOA ON | hac | perform 1 - Ya | ned? | of c | mpletion of ceuse death? Yes 2 No | | |
| director, | To Be Completed | | 28a. Data of Injury | ER/Outpatient 3 28b. Tima of | DOA | her: 4 Nursing | perform | ned? as 2 No e) ance 8 □ O | thar (Specify | mpletion of ceuse death? Yes 2 No | | |
| director, | To Be Completed | axaminer? 1 Yas 2 No 27. Manner of Death 1 Natural 5 Panding | 28a. Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Inju | her: 4 Nursing ry at rk? | perform 1 □ Ya ath (Check only on Homa 5 □ Rasida | ned? as 2 No e) ance 8 □ O | thar (Specify | mpletion of ceuse death? Yes 2 No | | |
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| | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner m | |
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| THAILMENT HE LAW REQUIRES THAT THE DESTRICTED BE EXPECTIVED WITHIN 24 NOUTS THE DESTRICT BATH. Page 6 may be retained by the hospital or attending physician. | ter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | or item 23 shows any injury, or other traymatic event, the medical examiner must be notified at once |
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| HOWARD N. COOK, SR. 1. SOCIAL SECURITY HUMBER 2.34-01-9257 1. STATUS AND ADDRESS OF THE CONTROL AND ADDRESS OF THE ADDRESS | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3 | | | | | | | | | | |
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| SOURCE SCURITY NUMBERS S. SEC. A LOSE of the not belong When the provided Sec. Control Sec. Se | HOWARD N. COOK, SR. JANUARY 17. 1996 | 9:39 A. M | | | | | | | | | |
| The ALCOLATION MADE for imministry the size and authority A RECENT WARREL FOR PRINCIPLE AND ADDRESS OF SECURITY BASE DEFICES THE ADDRESS OF DECEMBER T | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. linst birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPL | | | | | | | | | | |
| TREDERICK MEMORIAL HOSPITAL FREDERICK FREDERI | 234-01-9257 1 M 2 G F 78 VRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) AUG. 13. 1917 WEST | VIRGINTA | | | | | | | | | |
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| Secondary Seco | ROULE 4, BOX 503 25401 U. S. A | . • | | | | | | | | | |
| 1. S. DECEDENT SEMANCHION (Choody only highest grade composition) (Choody only highest | | - American Indian, White, etc. | | | | | | | | | |
| 16. DECEMBET SIGNATION 16. DECEMBET SIGNATION 16. DECEMBET SIGNATURE (Part Mode), Machine Survey (Part Mode) | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2XXNO Specify: Specify: | WHITE | | | | | | | | | |
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| No. MALING ADDRESS (Finest and Number or Plant Route Marches City or Daws, State, 2p Code) MR. CHARLES A. COOK 619 STATE CIRCLE, MARTINSBURG, WV 25401 ADDRESS (Finest and Number or Plant Route Marches and Plant Report Number of Plant Route Martinsburg) 254 December 1/2 December 1/ | NATHAN GOFF COOK BELVA STOKES | | | | | | | | | | |
| TR. CHARLES A. COUR 19 STATE CIRCLE, MARTINSBURG, WV 254.01 | 198. INFOHMANT'S NAME (Type/Print) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 22. BASE AND PART I. Other deseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, intervited above, or heart failure. List only one cause on each line. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval 8 Due to (or As A COMSEQUENCE OF): 24. MARTINSBURG, WV 254.01 Approximation of the property arrest, interval 8 Due to (or As A COMSEQUENCE OF): 25. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval 8 Due to (or As A COMSEQUENCE OF): 26. SEVERE CLOSED HEAD INJURY DUE TO (or As A COMSEQUENCE OF): 27. MARTINSBURG, WV 254.01 Approximation of the property arrest, interval 8 Due to (or As A COMSEQUENCE OF): 28. PLACE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 29. PART II. Other significent conditions contributing to death but not resulting in the underlying course given in Part I. 29. PLACE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 29. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 29. PLACE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 20. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 29. PLACE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 20. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 20. PLACE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 20. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 20. PLACE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 21. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 22. PLACE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 23. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DUE TO (OR AS A COMSEQUENCE OF): 24. DATE SIGNATURE AND A COMSEQUENCE OF): 25. DATE OF TO (OR AS A COMSEQUENCE OF): 26. DATE SIGNATURE AND A COMSEQUE | MR. CHARLES A. COOK 619 STATE CIRCLE, MARTINSBURG, WV 25401 | | | | | | | | | | |
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| BROWN FUNERAL HOME, 327 W. KING STREET PO BOX 821, MARTINSBURG, WV 254.01 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest. Approximate the disease of condition of the cause on sach line. Approximate the deeth. | 4 Donation 5 Other (Specify) ROSEDALE CEMETERY 1/20 MARTINSBURG, | WV | | | | | | | | | |
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| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO XX UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO XX UNCERTAIN | PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WI | ERE AUTOPSY FINDINGS | | | | | | | | | |
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| Netural S Pending Investigation 1/16/96 2:00P M 1 YES 2 No SLIPPED ON ICE | | | | | | | | | | | |
| Netural S Pending Investigation 1/16/96 2:00P M 1 YES 2 No SLIPPED ON ICE | | _ 165 2 _ NO | | | | | | | | | |
| Netural S Pending Investigation 1/16/96 2:00P M 1 YES 2 No SLIPPED ON ICE | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| Netural S Pending Investigation 1/16/96 2:00P M 1 YES 2 No SLIPPED ON ICE | OTHER: | | | | | | | | | | |
| Netural S Pending Investigation 1/16/96 2:00P M 1 YES 2 No SLIPPED ON ICE | 27. MANNER OF DEATH 28s. DATE OF INJURY 28s. TIME OF 28c. INJURY AT 28sd DESCRIBE HOW INJURY OF COUNTY | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER) 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. PLACE OF INJURY — At home, larm, street, factory, office Chy or Rown, State) RT . 4, BOX 503, MARTINSBURG, WV 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER) 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. PLACE OF INJURY — At home, larm, street, factory, office Chy or Rown, State) RT . 4, BOX 503, MARTINSBURG, WV 29a. CERTIFIER 29d. DATE SIGNED (Month, Day, Year) | 1/16/06 2.00D M 4 Type ACT IN CT TRAIN ON TOR | - 0 | | | | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER? 296. LICENSE NUMBER D44213 296. DATE SIGNED (Month, Day, Year) 296. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI YALAMANCHILI, MD; 198 THOMAS JOHNSON DRIVE #6, FREDERICK, MD 21702 31. DATE FILED (Month, Day, Year) 32. REGISTRAR SIGNATURE | 3 Suicide 8 Could not be 288. PLACE OF INJURY — At home, larm, street, factory, office 281. LOCATION (Street and Number or Rural Rout | le Number, | | | | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER? 296. LICENSE NUMBER D44213 296. DATE SIGNED (Month, Day, Year) 296. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI YALAMANCHILI, MD; 198 THOMAS JOHNSON DRIVE #6, FREDERICK, MD 21702 31. DATE FILED (Month, Day, Year) 32. REGISTRAR SIGNATURE | | JRG,WV | | | | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER? 296. LICENSE NUMBER D44213 296. DATE SIGNED (Month, Day, Year) 296. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI YALAMANCHILI, MD; 198 THOMAS JOHNSON DRIVE #6, FREDERICK, MD 21702 31. DATE FILED (Month, Day, Year) 32. REGISTRAR SIGNATURE | 29s. CERTIFIER (Chack not). CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(a) and menner as stated | | | | | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER? 296. LICENSE NUMBER D44213 296. DATE SIGNED (Month, Day, Year) 296. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI YALAMANCHILI, MD; 198 THOMAS JOHNSON DRIVE #6, FREDERICK, MD 21702 31. DATE FILED (Month, Day, Year) 32. REGISTRAR SIGNATURE | | nd menner as stated. | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI YALAMANCHILI, MD; 198 THOMAS JOHNSON DRIVE #6, FREDERICK, MD 21702 31. Date filed (Month, Day, Year) / 198 THOMAS SIGNATURE | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI YALAMANCHILI, MD; 198 THOMAS JOHNSON DRIVE #6, FREDERICK, MD 21702 31. Date Filed (Month, Day, Your) / A 28, REGISTRAR SIGNATURE | The state of the s | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 2, REGISTRAR SIGNATURE | 1044213 | 9 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 2, REGISTRAR SPIGNATURE | | | | | | | | | | | |
| II I I D T Y TUUL (MATA MATAMAAN KAAN K | 30. NAME AND ADDRESS OF PERION WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | |
| FEB 1 3 1996 Jaha Wheeler Rashill | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI YALAMANCHILI, MD; 198 THOMAS JOHNSON DRIVE #6, FREDERICK, MD 21702 31. DATE FILED (Month, Day, Your) 22. REGISTRAR SIGNATURE | | | | | | | | | | |

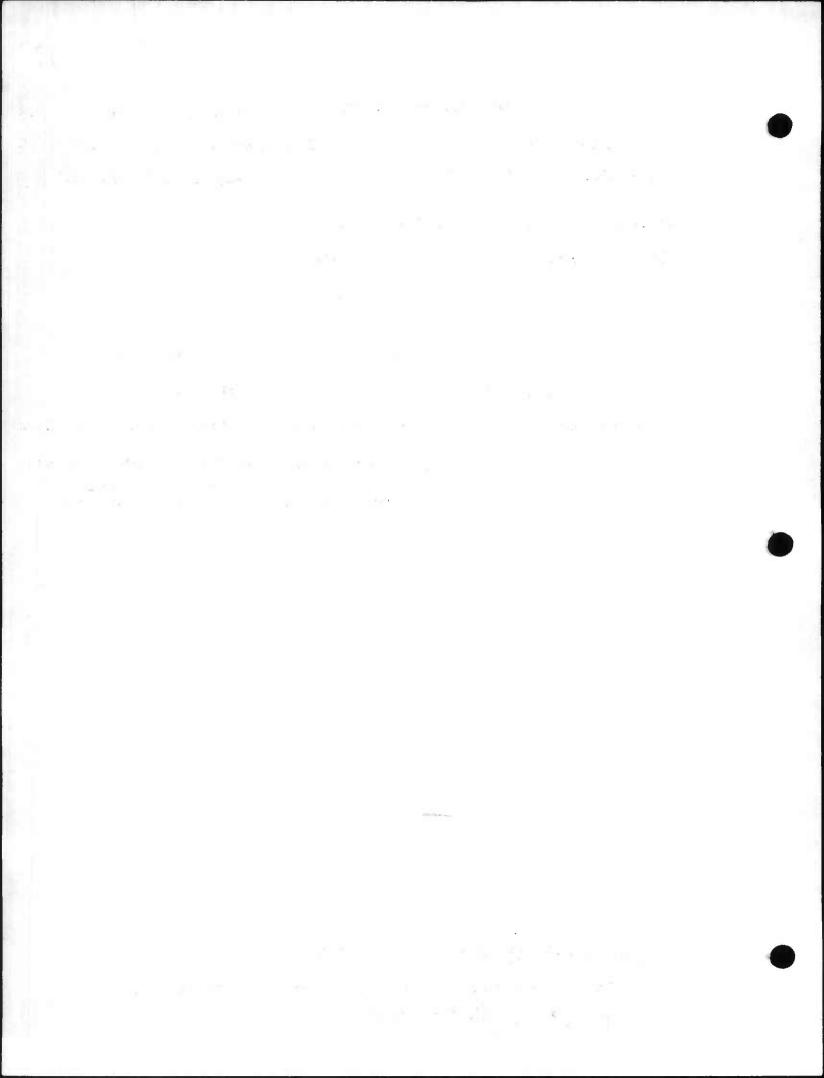
ITEM: 26. PER DR. OFFICE Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible

FILM 6-732 2/13/96 t.t

State of Maryland / Department of Health and Mental Hygiene 96

03530

| | | | | | | C | ertificate | of | Death | | | Reg. No. | | |
|---------------------|---|----------------|--|------------------------------------|--|----------------------------------|---------------------------------|---------------|---------------------|-------------|------------------------------|-------------------|--------------|-------------------------|
| | | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of De | | Vess | 3. Time of Death |
| | Physic /Medi | | | Agnes | Victo | oria | Dulski | | | | Month Februa | cv 9 | 1996 | 7:15 A.M |
| } | Exami | | 4e. Facilify Name (If not institution, | | | 4b. City, Town, or Location of D | | | - | ty of Death | | | | |
| | | | 264 - 11th Str | eet | | | | | Chels | ea F | Reach | Anne | Arun | del |
| - | Funeral | Н | | | 7. Age (In yrs. | last birthda | y) If Under 1 | | ff Under | | 8. Date of Bir (Month, De | | | placa (Stete or Foreign |
| П | Director | | 213 50 3705 | 1□M 2 ⊠ F | 78 | Yrs. | Months | Days | Hours | Min. | (Month, De | | | yland |
| | | | Usuel Residence of Decedent | | | | | | | | nugust | 20/1/ | Plat | yrand |
| | ylan | | 10e. Stete 10b. County | | 10c. Cit | y, Town or | Location | | | | | | | 10d. fnside City Limits |
| | Ma T | Ş | Maryland Anne A | rundel | Ch | nelsea | a Beach | | | | | | | 1 ☐ Yes 2 ☒ No |
| | r 28 | Director | 10e. Street and Number | | | | 10f. Zip (| ode | | | | 10g. Citizen of | What Cou | intry? |
| | h wit | | 264 - 11th Stre | eet | | | 2 | 2112 | 22 | | | U. | S. | |
| | n 72 hours after death with the Maryland "natural", or flems 23a or 28a-f show solicel Examiner must be notified at | Funeral | 11. Meritel Status | 12. Was Dece | edent Ever In U | ,S. 1: | 3. Wes Decede | nt ot l | Hispenic Orig | gin? (Sp | ecify Yes or No | | | can Indian, |
| 0 | after A | | 1 Never Merried 2 Married | Armed Fo | 2X No | | It Yes, specif | | | i, Puerto | Hican, etc.) | | eck, White | , etc. |
| 02 | Mary Mary | þ | 3€ Widowed 4 Divorced | If Yes, Giv Yeer or Do | | | 1 □ Yes 2 | ∆l No | Specify: | | | Spec | ity: W. | hite |
| 2-0 | 72 ho | Completed | 15. Decedent's | Education | - | 18e. De | cedent's Usuel | Occup | pation | t mil same | t | 16b. Kind ot | Business/Ir | ndustry |
| 21 | E . 5 | ple | (Specify only highest (Elementary/Secondery (0-12) | College (1 | -4or 5+) | life | ve kind of work . DO NOT use | retire | i dunng mosi id) | OF WORK | ing | | | |
| 21 | O Po to | 0 | 8th | | | Ho | me Make | er | | | | In own | n home | 9 |
| nd | be filed that Hygie d other event, to | Be (| 17. Father's Name (First, Middle, La | st) | | | | | 18. Mothe | r's Nem | e (First, Middle | Meiden Surne | me) | |
| /la | | To | | Frank C | ada | | | | | Ag | nes Po | savad | | |
| Maryland 21215-0020 | d 2 should th and Mer 7 is marke traumatic | | 19e, Informant'e Neme/Reletionship | (Type, Print) | | 19b. Me | iling Address (| Street | t end Numbe | or or Run | al Route Numb | er, City or Tow | n, State, Zi | p Code) |
| | E = 64 . | | Anthony Dulski | | | 264 | - 11th | St | treet | C | helsea | Beach, | Mary | land 21122 |
| e e | f Heal | | 20e. Method of Disposition | | | Pleca of Dis | position (Nemeremetory or oth | of er nie | ice) | i | Dete | 20c. Location | - City or T | own, State |
| Ë | Page ent m: If y or | | 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Spe | | 21616 | | deemer | | | 12 | /12/96 | Baltin | more, | Maryland |
| altimore, | permit. Pages 1 ar Department of Hea Important: If Item 2 any Injury or other 2005. | 1 | 21. Signetuge of Funeral Service Lic | | 110. | I INC. | 22. Neme end | | | | | | | |
| ä | Depa Impo any l | | Make Dri |) . | | ¿ | | | | | Gonce I | | | |
| | _ | | 23e Porti Enter the disease or d | policetions that or | oused the deat | | | | | _ | y Balt | | MG. | Approximete |
| | Di | | shock, or heart tellure. Call only one cause on each line. | | | | | | | | | | | |
| | Physician /Medical | | Immediete Ceuse (Finel | | | | | | | | | | | Onset and Deeth |
| | Examiner | | diseese or condition resulting in deeth) | е. Муо | cardia1 | Inta | rction | | | | | | - 1 | Immediate |
| | | Į. | Due to (or es a consequence ot): | | | | | | | | | | | |
| | pet nsit | 듣 | | ■ b.——Art | eriosci | eroti | c Hear | ב ט | isease | е | | | | Years |
| | pertificate be axecuted ding physician and se as the burist-transit | Examiner | | | | | | | | | | i | V | |
| 9 | be a siciar buri | | | | | | | | | | | i | Years | |
| 68760, | phys s the | edicai | thet minuted events Due to (or as a consequenca of): | | | | | | | | | | | |
| × | di je | 3 | | d. Pas | sive to | bacco | smoke | ex | posure | е | | | | |
| 8 | daath c e attan | Physician | | | | | | | | | | | | |
| o. | 0 0 2 | iysi | Part II. Other significant conditions | _ | | - | | _ | | | | | | to the cause of death? |
| ۵. | that the led by th detache | | | | | | | | | 3 Pro | bably 4 Unknow | | | |
| ds | requires ween sign hould be | d by | Arterioscleroti | c cardio | vascula | r dis | sease, | com | plete | | 240 18/00 | en eutopsy | 24h W | /ere autopsy findings |
| ò | | Completed | | | | | | | | | perfo | med? | ar | veilable prior to |
| 3ec | 2 8 8 | ig. | heart block, st | atus pos | t pacem | naker | · | | | | | | of | death? |
| <u></u> | T age | Ö | | | | | | | | | 10 | Yes 2 No | -1 | □Yes 2ÇMo |
| of Vital Records, | Physician: The this certificata rai director, par | Be | 25. Was case reterred to medicel exeminer? | | | | | | | ot Deet | h (Check only | one) | | |
| 5 | Physic this c | ို | 1 ☐ Yes 2XXNo | Hospital: 1 🗆 Ir | npatient AA | ER/Outpat | | | | rsing Ho | me 5XXResi | dence 8 🗆 O | ther (Speci | (ty) |
| | fler t | ü | 27. Menner of Deeth 1 Neturel 5 □ Pending | 28e. Dete d (Mont) | of Injury h, Dey Year) | 28b. Time Injury | of 28 | c. Inju Wo | ry et ork? | | 28d. Describe | how injury occi | urred | |
| Division | Attending or death. ector: Afte by the fund | Certification: | 2 Accident Investiget | | | | М | 1 | Yes 2 1 | No | | | | |
| Ž | after d Direct | # | 3 ☐ Sulcide 6 ☐ Could not 4 ☐ Homicide determine | 28e. Plece buildin | 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 28t. Location (Street a City or Town, Ste | | | | | | ber or Rui | ral Route Number, | | |
| | is after or all Dir | | | | | | | | | | | | | |
| | To the Hospital or Atlanding I within 24 hours after death. To the Funeral Director: Atler completely filled in by the funer | edical | 29e. Certifier Certifying (Check only 2 Medical Ex | hysician: To the aminer: On the ba | best of my kno | wiedge, de | eth occurred et | the ti | me, dete en | d plece, | end due to the | ceuse(s) end r | nanner es | steted. |
| | the the | 8 | One) | end mann | er steted. | | | | | ur occurr | oo ot are time, | doto ond place | , and dde i | o the cause(s) |
| | 5 × 5 × 6 | Σ | 29b. Signeture and too ot certitler | /. | | ^ | 29c. | Licens | se number | | | 29d. Dete sign | ed (Month, | , Day, Year) |
| | | | MELANI | 1 Agric | O MM | () |] | 022 | 633 | | | 2-12-96 | 5 | |
| | 12 | | 30. Name and eddress of person wh | o completed cause | e of deeth (Item | n 23a) (Typ | e, Print) | | | | | | | |
| | 10. | | Wr. Jorge Se | cada-Lov | io | 7401 | l Osler | Dr | ive | Т | owson, | Maryla | nd | |
| | Sta | ite | 31. Dete filed (Month, Dey, Year) | 32. Re | agistrar's Signa | dure p | . 0. 11 | | | | | - | | |
| | Registr | ar | FEB 1 | 1996 | acua acinos | MARKY BV | AGE P | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: 4c, PER F.H. FILM G-732 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Month **Physician** DOERFLER : 10 pm GERARD FEBRUARY 1996 10 Joseph /Medical 4e. Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL GOOD SAMARITAN BALTIMORE House 1 Year If Under 24 Hrs. 8. Data of Birth North, Deys Hours Min. Sept. 08, 1920 Balto.Maryland 5. Sociei Security Number 6. Sex 7. Aga (In yrs. lest birthday) **Funeral** 1√□ M 2□ F 215-14-0782 75 Yrs. Director Usuei Residenca of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYas 2 No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2, and yillury or other traumatic event, the Medical Francisco. 5760 Maplehill Road 21239-3245 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Biack, Whita, atc. 1 XYas 2 □ No If Yes, Giva Yeer or Delas1942-1946 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Eiamentary/Secondery (0-12) College (1-4or 5+) Postal Clerk U.S.Post Office 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Malden Surneme) Peter Joseph Doerfler Mary Diehl 19e. informent's Neme/Raiationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret G. (neeWagner)Doerfler 5760 Maplehill Road Baltimore, Md. 21239-3245 20a. Method of Disposition
1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from Stete 20b. Piece of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, State Dulaney Valley Mem.Gard. 02/14/96 Cockeysville, Maryland 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Sarvice Licensee Leftrey L. Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 In dispasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset end Deeth **Physician** Immadiata Causa (Finel disaase or condition resulting in deeth) /Medical · CARDIOMYOPATHY Examiner Dua to (or as a consequence of): CORONARY 32432rd HEART nding Physician: The law requires that the death certificeta be executed Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Lest Due to (or es e consequenca of): Jivision of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequenca of): Pert if. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Vunknown CHRONIC PLEURAL EFFUSION signed b þ 24b. Were eutopsy findings avelleble prior to completion of causa of deeth? Completed 24e. Wes en eutopsy performed? certificate has birector, page 2 s 1 ☐ Yes 2 ☐ No director, Be 25. Wes casa referred to medical axaminer? 28. Piaca of Daeth (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred Medical Certification: Athar 5 Pending invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 - Homicide 29e. Cartifier 156 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and plece, end due to the cause(s) end mannar as stated.
2 Medical Examiner: On the bests of exeminetion and/or investigetion, in my opinion, death occurred et the time, deta and place, and due to the cause(s) and menner stated. To the Hosy within 24 ha To the Fund completely I 29b. Signetura and title of certifier 29c. Licensa number 29d. Dete signed (Month, Day, Year) P09303 anni MB ChB FEBRUARY 10 1996 30. Name and eddress of person who complated cause of deeth (Item 23e) (Type, Print)

ANNE OWNER MD, GOOD SAMARITAN HOSPITAL, SOOI LOCH RAVEN BLUD, BALTIMORE MD 21239

FEB 1 \$ 1996 > Juli d'Autles Radell

State Registrar

31. Dete filed (Month, Day, Year)

Always S.M. John Park

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 40 Am ENGENE Michael DUFFY 1996 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE TOWNSHIP If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 M M 2 ☐ F 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 69 Yrs. 216203671 68 Director Usual Rasidence of Decedant the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Dundalk Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental hygiene. Important: If I fem 27 is marked other than "not any injury or other traumate." 15 Township Road 21222 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Bieck, White, etc. 1 XYes 2 No 45-7/47 Year propares: 7/51 1 ☐ Never Merried 2 🔀 Merried 1 ☐ Yes 2 ☐XNo Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12th grade 3 years Chemical Product Supervisor W. R. Grace 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Joseph Michael Duffy Lillian Delano Jones 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jane D. Duffy (wife) 15 Township Road-Baltimore, Maryland 21222 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stata Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 X Donetion 5 ☐ Other (Specify) 21. Signature of Furnieral Service Licensee ROPALC State knatomy Board-655 W. Baltimore Street s (wade, Dir, RYLLING BOATA-655 W. BALTIMORE St. St. Baltimore, Maryland 21201-1559 art. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hock or heart failure. List only one cause on each line. Physiclan Immedieta Causa (Finel diseese or condition resulting in deeth) /Medical e. Poorly diperentiated adenocaranoma of lung Due to (or es e consequence of): 20 months Examiner Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Fureral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be deteched for use as the burlet-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasuiting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings evallable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? s certificate hes b director, page 2 s 1 Yes 20 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Placa of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? 5 Pending 1 Naturel investigetion 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, deta end place, end dua to the cause(s) end mannar es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end mennar stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Matilda H. So, mo D26250 30. Name end eddress of person who completed cause of daeth (item 23a) (Type, Print) 1447 YORK RD LUTHGRVILLE, MD. 21093; MATILDA H. 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State Registrar

The second of th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3 Time of Death Month **Physician** Willie Mary 25T A Felo /Medical 4a, Fecility Nama (If not institution, wa street and pumber) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI HOSPITAL BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** Months 1□ M 2□XF Yrs 218-12-0914 Director 05/30/1908 GEORGÍA Usuai Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinet trait be nothed at 1 XYes 2 No Director MARYLAND BALTIMORE BALTIMORE 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of What Counfry? with 1 2709 GLEN **AVENUE** 21215 U.S.A. death Funeral 14. Race - American Indian, Biack, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritei Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or flem any injury or other traumatic avant. 1 ☐ Never Merried 2X Merried 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Buainess/Induatry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 HOMEMAKER HOME 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Meidan Sumame) JOHN GREENE MATTIE GREENE 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SHIRLEY NICHOLSON (DAUGHTER) 2709 GLEN AVENUE BALTIMORE, MARYLAND 21215 20b. Piece of Disposition (Name of cematery, crematory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Dete 1X Buriel 2 ☐ Crametion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN CEMETERY 2/ 15/96 WOODLAWN, MARYLAND ESTEP BROTHERS FUNERAL HOME PA. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217 23a. Pert1. Pater the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Fine) Small Bowel diseese or condition resulting in deeth) Examiner Examiner lenccarcinoma bunial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest and Due to (or es e consequença of) Box 68760, physician that the death certificate be Physician/Medical the Due to (or es e consequenca of): esn esn igned by the a be detached f Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. vision of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? dependent signed by 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu has certificate 1 ☐ Yes 2/2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After ending 1 Neturei 5 Pending 1 Yes 2 No laath. investigetlon 2 Accident ö 6 Could not be 3 Suicide 26f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end manner as ateted.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, and due to the cause(s) end menner steted. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) AS 24 0232 ARCI725 30. Name and address of person who completed cause of death (item 23e) (Type, Print) Baltimor Sinai. Hospital 21215 ms

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State Registrar 31. Dete filed (Manth, Dey, Year) FEB 1 3 1996

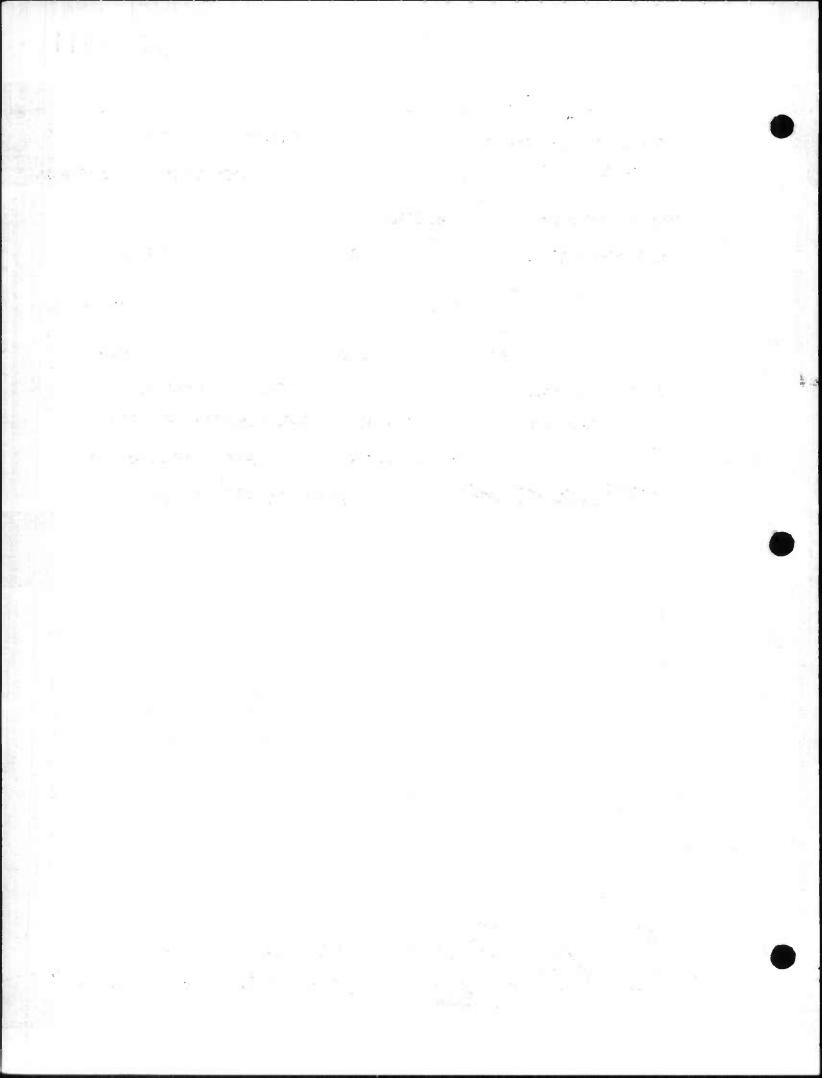
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32. Fli gistrer's Signature

| | | | State of W | iaryiariu / | Certificate of | | | Reg. No. | 03334 |
|---------------------|---|-------------------|--|----------------------|--|---|---------------------------------------|---------------------------------------|--|
| | Physic /Medi | | 1 Decedant's Neme (First, Middle, Last) Don a (cl Dirk | ns or | | | 2. Date of De Month | Dey // | Year 96 Srozan |
| | Exami | | 4a. Facility Nema (If not Institution, giva street and number | | | 4b. City, Town, or Baltimo | | h 4c. County | of Deeth |
| | Funeral Director | | 203-07-9800 ^{1⊠ M 2□ F} | ige (In yrs. lest bi | irthday) If Under 1 Year Months Deys | If Under 24 Hrs. Hours Min. | | th ov, Year) | 9. Birthplace (Steta or Foreign Country) Pennsylvania |
| | bud wo | | Usual Rasidance of Decedent 10a. Stata 10b. County | 10c. City, Tov | wn or Location | | | | 10d. Inside City Limits |
| | Mery First | tor | Maryland Baltimore | Parkvi | ille | | | | 1 ☐ Yas 2 ⊠No |
| | or 28 | Director | 10e. Street and Number | | 10f. Zip Code | | | 10g. Citizen ot W | /hat Country? |
| | oth w | | 8800 Walther Blvd. | | 21234 | | | U.S.A | |
| 020 | n 72 hours after deeth with the Meryland *natural", or Hems 23a or 28a-f show edical Examiner mast be neutral | by Funeral | 11. Marital Status 1 □ Never Merried 2 □ Merried 1 □ Never Merried 2 □ Merried 1 □ Yes 2 If Yas, Give Yaar or Dates | ?] No | 13. Wes Decedent of H If Yas, specify Cubi 1 ☐ Yes 2 □ No | dispanto Ortgin? (S an, Mexican, Puart Specify: | pecify Yee or No o Rican, etc.) | | e - American Indian, k, White, etc. . White |
| Maryland 21215-0020 | C 2 | Completed | 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or | 168 | | | | 16b. Kind of Bu | |
| 21 | e filed withing Hygiene. other than | Com | 5+ yr | | Professor | | | Educa | |
| and | s 1 and 2 should be filed I Health end Mental Hyg tem 27 is marked othe other traumatic event, | Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nen | | , Meldan Sumami augherty | |
| aryl | 2 should be end Mental is marked or sumatic ever | 10 | Charles F. Dickinson 19a. Informent's Neme/Ralationship (Type, Print) | 19 | b. Meiling Address (Street | | | | |
| M. | 1 and 2 Health e | | Marjorie Dickinson | | 8800 Walther | | | | |
| Baltimore, | 80= 2 | | 20e. Method ot Disposition 1 □XBurial 2 □ Cremetion 3 □ Removei trom State 4 □ Donation 5 □ Othar (Specify) | cemata | ot Disposition (Neme of ary, cremetory or othar plea ey Valley | , | Deta 2-14 | 20c. Location - (| City or Town, Stata |
| Balt | permit. Pe Departmer Important: any injury once. | | 21. Signeture of Funeral Service Licensaa | 1/ | 22. Name and Addra Ruck Tow 1050 Yor | • | al Home | , Inc. | |
| | _ | | 23a. Part1. Entar tha disaasa, or complications that cause shock, or haart tailura. List only one cause on aech | ed the death. Do | not antar tha mode of dyir | k Rd. Towng, such es cardied | VSON, MO or reepiretory e | rrast, | Approximete Intervel Between |
| | Physician /Medical Examiner | J. | Immediate Causa (Final disease or condition resulting in deeth) | ysen | a consequence of): | | | | Onset and Death |
| ,00 | ficete be executed physician and is the buriel-transit | √Medicai Examiner | Sequentially list conditions, if eny, leeding to Immediate causa. Enter Underlying Causa (Disease or Injury | Due to (or es e | consequence ot): | | | | |
| Box 68760, | ding se a | | that initiated events resulting in death) Lest | Due to (or as a | consequence of): | | | | |
| | death e atten | sicia | Pert II. Other significant conditions contributing to death | but not rasuiting | In the underlying causa giv | van in Pert I. | 23b. Dld | tobacco use con | tribute to the cause of death? |
| S, P.O | thet the ed by th deteche | by Physician/M | | | | | 1 | | 3 Probably 4 Unknown |
| Records, | ew requast been 2 shoul | Completed | - | | | | | an autopsy ormed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
| = | The ate h | Con | | | | | 10 | Yee 2000 | 1 ☐ Yee 2 ☐ No |
| of Vital | Physician: The I this certificate he | o Be | 25. Wes case raferred to medical exeminar? 1 Yes 2 No Hospital: 1 Impat | | Oth | 26. Place of Dee | | | |
| | | - | 1 | ury 28b. | Time of Injury 28c. Injur | 4 U Nursing H | | dence 6 Otha how Injury occurre | |
| | 7 5 5 C | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Ir | njury - At home, to | erm, street, fectory, office | | | | er or Rural Roule Number, |
| | To the Hospital of within 24 hours of To the Funeral D completely filled in | edical | 29a. Certifier (Check only one) 2 Gertifying Physician: To tha best 2 Medical Examiner: On tha basis end mannar s | ot examination er | e, deeth occurred et tha tin nd/or investigetion, in my o | na, data and piece | , and due to the rred et the time, | cause(s) and mer date and plece, s | nner es steted. ind due to the cause(s) |
| | To t To th | ž | 29b. Signature and ettle of certifier | 1 | 29c. Licens | | | 29d. Date signed | (Month, Day, Year) |
| | | | roug/Chi | 700 | 3 96 | 5001 | | 2- | 11-96 |
| | | - | 30. Name and address of person who completed cause of | death (Item 23a) | (Type, Print) | · 11. | lan- | Bazview | Mr O Catu |
| | Sta | te | 31. Date filed (Month Day Year) 1. Ma Settember | Randadhuro | 7 0~ | - 1 do | US | Julen | mu was |
| | Registr | | FER 1 3 1930 | | | | | | - |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month 02 MARY AGNES DRUMWRIGHT 1996 8:35p.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1107 N. MOUNT STREET BALTIMORE N/A If Undar 1 Year If Undar 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 04-03 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 287 F 75 212-22-4273 Yrs Director MARYLAND Usual Residence of Decedant with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shows notified at 1 to Yas 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 1107 N. MOUNT STREET 21217 USA Completed by Funeral Peges 1 and 2 should be filed within 72 hours efter death vent of Health end Mentel Hygiene.

Int: If flean 27 fs marked other than "natural; or Itema 23 inty or other traumatic event, the Medical Examiner may 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Biack, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify: Specify: BLACK **¾**□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) HOME MAKER N/A 12th 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surneme) Be PATTERSON MARGURITE NEWMAN ELMO 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Intormant's Name/Relationship (Type, Print) 1107 N. MOUNT STREET, BALTO. MD. 21217 MARY OWENS 20a. Method of Disposition 20b. Place of Disposition (Nema of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) MD. NATIONAL CEM. 02-14-96 LAUREL. MD. 21. Signature of Funeral Sendos Licenses 22. Name and Addrass of Facility ALBERT P. WYLIE F/H 638 N. GILMOR STREET 21217 238. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediata Cause (Finel disaasa or condition resulting in daath) Metastatic Pancreatic Cancer 3 months Examine Examiner sician and burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical the Due to (or as a consequenca of) been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sivision of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause ot death? Completed 24a. Was an autopsy performad? page 2 certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No afferding Physician: 1 afferded: 7 Prector: After this certifica funeral director. Be 25. Was casa reterred to medical examiner? 26. Piaca ot Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Pesidenca 6 Other (Specify) Medical Certification: To 27. Mannar ot Deat 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accidant 5 Panding invastigation 1 ☐ Yes 2 ☐ No In by the 3 Suicide 6 Could not be 28t. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At homa, tarm, straat, tactory, office building, etc. (Specify) 4 Homicida 29a. Cartifian To the best of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To the comple 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 29c. Licanse number 30. Name and address of person who completed causa of death (item 23a) (Type, Print) University of Maryland Department of Acheine 22 S. Greene St. Baltimme, MD 21201 Stephen L. Lin 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

March 1

Please Type or Print in Black Indelible ink. Assure All Copies Are I State of Maryland / Department of Health and Mental Hygiene Q 6

| | | | | | Olato of III | ar y rarr | Ce | ertifica | ate of | Death | Wiemanny | Reg. No. | b U | 35 | 36 |
|------------|---|-------------------------------|--|---|--|----------------------------|--|--------------|--------------------------------------|---|--|---|------------------------------------|--------------------------|-------------------------------------|
| | Physici /Medic | | 1. Decedent's Name | | LEISHE | LL | | | | | 2. Date of De Month FEB. | | Year 1996 | | ne of Death 13 A.M. |
| | Examir | | 4a. Facility Nama (If | | | | r Location of Deat | h 4c. Count | | N. | /A | | | | |
| L | | | 5. Social Sacurity Nu | | EUE ST. | | LTIN: | | der 1 Year | BALTI M | | 314 | HORE | | - |
| L | Funeral Director | | 244-34-84 Usual Rasidence of [| 139 11 | M 2XF | 70 | Yrs. | Month | | Hours Mir | | , 1925 | N. Ca | aca (Sta iny) arol | ina |
| | ylend | | 10a. Stata | 10b. County | N/A | 10c. City | , Town or I | Location | | | | | 10 | | la City Limits |
| | Ba-1s | ctor | MD | 30 | N/A | B | ALTIL | ORE | | | | | | 1 🖙 | Yes 2□No |
| | th with th | al Dire | 10e. Street and Num | | RT AVEN | SUE | | | Zip Coda 212 | 30 | | 10g. Citizan of | What Coun | iry? | |
| 020 | permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a 4 show any Injury or other traumatic event, the Medical Examinat must be notified at ance. | Completed by Funeral Director | 11. Marital Status 1 ☐ Never Marrie 3 ─ Widowed 4 | | 12. Was Decedant Armed Forcas? 1 ☐ Yas 2 1 If Yas, Giva Year or Datas: | Evar In U, | S. 13 | | cedant of F pecify Cub 2 10 No | | Specify Yas or Norto Rican, atc.) | Specif | ce - America ck, Whita, a | | |
| 21215-0020 | filed within 72 h Hygiene. ther than "natu | ompletec | (Specification (Speci | 15. Decedant'a Ed y only highast grad dary (0-12) | cation la completed) Collaga (1-4or | | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) Home Maker | | | orking | 16b. Kind of B | | | | |
| | Hygin of the orther | Be Co | 17. Father's Nama (F | irst, Middle, Last) | | | ** | Onic 1 | MICE | 18. Mothar's Na | ame (First, Middle | | | - | |
| /lar | should be nd Mentel merked o | To B | | J | ohn Welc | h | | | | I | Dora M. (| Gibson | | | |
| Maryland | d 2 sho th end 7 Is me traum | | 19a. Informant'a Nan Susan Di | | ype, Print) | | | - | | and Number or F Avenue | Raltimo | | | , | 25 |
| - | s 1 and f Health tem 27 other tr | | 20a. Mathod of Dispo | | | 20b. Pi | lace of Disp amatary, cr | | | | Data | Baltimore, Maryland 21225 Data 20c. Location - City or Town, State | | | |
| imo | Peges nent of I ant: If the ary or o | | | Cremation 3 □ | Ramoval from State | 1 | | | | | 2/13/96 | Baltir | nore, | Mar | yland |
| Baltimore | permit. Peg Department Important: I any Injury o | | 21. Signature of Fun | eral Service Licens | 2 | | / | 22. Nama | and Addra | ss of Facility | Gonce | Funeral | neral Home P.A. more, Md. 21225 | | |
| В | THE PARTY | | 23a. Part1. Enter the shock, or heart | disease, or mone feilure. Lint out o | ications that caused ne cause on each li | d the daeth | n. Do not e | ntar tha m | ode of dyl | ng, such as cardi | ac or raspiratory a | mest, | PIG. 2 | Approx | |
| | Physician /Medical | | Immadiata Causa (F disaasa or condition | | MIOCA | | | | | | | | | Onsat a | DAYS |
| п | Examiner | _ | rasulting In death) | | | | r as a cons | | | | | | 1 | | 0/192 |
| | nsit | Examiner | | | b. NECRO | | | | | | | | | 31 | AUS |
| o, | exact an and rial-tra | | Sequantially list condit any, laading to Imnocausa. Entar Undark Cause (Disaasa or Inthat initiated avents | ditions, nediata vino | SEVERI | | as a cons | | | | | | į | | 0.00 |
| x 68760, | eath certificate be executed attending physician and for use as the burial-transit | /Medical | Cause (Disaesa or In that initieted avents rasulting In daath) La | ist | d | | as a conse | | | EASE | | | | 50 | HAZ |
| . Box | death d for u | iclar | Part II. Other signific | ant conditions co | ntributing to death b | ut not resu | ulting In the | underlying | n causa ais | en in Part I | 23h Did | tobacco use co | ntribute to | the car | see of death? |
| , P.O | requires that the death cer ween signed by the attendir hould be detached for use | y Physician/M | | | integrating to doubt b | | nung in tita | orioeriya (| y causa yn | Tall III F all I. | | Yes 2□ No | | | 4 Unknown |
| Records, | 2 s 5 | Completed by | | | | | | | | | | an autopsy ormed? | ava | rilabla pr | osy findings rior to of cause |
| - B | E age | Com | | | | | | | | | 10 | Yas 28 No | 10 | Yas | 2 No |
| Vital | ysician: The | Be | 25. Was casa rafarra axaminer? | | In a like to | _ | | | | | eath (Check only | ona) | | | |
| of | Phys this | To | 1 ☐ Yes 2 N 27. Manner of Death | 0 | lospital: | | ER/Outpatio | | DOA | | Home 5 Res | | |) | |
| Division | Attending Physician: Ir death. actor: After this certific by the funeral director, | Certification: | 1 Neturei 2 Accident 3 Sulcide | 5 Panding investigation 6 Could not be | 28a. Data of Inju (Month, Da | y Year) | 28b. Tima Injury | M | 28c. Injul Wol | rk? Yas 2□No | 28d. Dascribe | how Injury occu | rred | | |
| Divi | To the Hospital or Attending I within 24 hours after death. To the Fuheren Director: After completely filled in by the fune | | 4 Homlcida | datarmined | 28e. Place of Inj building, et | ury - At ho c. (Specify | ma, farm, s | treet, facto | ory, office | | 28f. Location (City or To | Street and Num wn, Stata) | ber or Rural | Routa i | Number, |
| · Comment | M Hosp n 24 hou is Futher pletely fill | edicai | 29a. Cartifier 1 (Check only 2 one) | Certifying Phy Medical Exami | sician: To the best of ner: On the basis of and mannar sta | axaminati | viadga, dea lon and/or l | th occurre | ed at the tir | me, dete end pleo opinion, daath occ | e, end due to the curred at tha time, | cause(s) and m date and placa, | annar as sta and due to | ated. the cau | sa(s) |
| | To the within 2 To the comple | M | 29b. Signature and til | de of certifier | gr 25 | | | 2 | 9c. Licens | se nu <i>m</i> ber | | 29d. Data signe | | | ar) |
| | 0 | | MACH | year, | H.D. | | | | A44 | 176435 | | Feb. 11 | ,1991 | 6 | |
| | 5 | | 30. Name end eddras | | | | | , Print) | | | | A 41 | | | |
| | Sta | te | 31. Date filed (Month) | Day, Year | Jaz. Pagistr | ar's Signat | 25.6 yra | REEX | JE 2 | 1. BAC | TIMORE | MD | | | |
| | D 1.4 | | FFD 1 | A IYYE | Alle Water | dear | A STATE OF | | | | | | | | |

manager from the g STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1 - FOR STATE REGISTRAR

| | | 1. DECEDENT'S NAME (First, | Middle, Last) | | hn | Ann L | essig | Fir | n | | MONTH | DE DEATH DA | | YEAR 996 | TIME OF DEATH |
|---|---------------|---|--------------------------------|--------------------------|-----------------------------|---------------|------------------------|------------------|----------------------------|-------------|---|---------------------------------|-------------|--------------|---------------------------------|
| | | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In | yrs. last bir | | NDER 1 YEA | | ER 24 HRS. | | F BIRTH Day, Year) | | | ACE (State or Foreign |
| 2 | i | 196-05-3916 | | 1 □ M 2 🂢 F | 8. | 3 | YRS. MONT | THIS DAY | rs HOURS | MIN. | | . 12, | 1912 | | nsylvania |
| 3 should | CC | 90. FACILITY NAME (# not in | | Ireet and number) | | | | | VN OR LOCA | | EATH | | 9c. COUN | TY OF DEA | тн |
| 1, 2, 3 | RECTOR | Sinai Hospi | | | | | | Balt | imore | | | | | N/A | |
| sades | REC | 10a. STATE | 10b. COUNT | Y | | -10 | Oc. CITY, TO | | | | | | | 10 | Dd. INSIDE CITY |
| H. P | ۵ | Maryland 100. STREET AND NUMBER | N/A | | | | Bal | timo | 101. ZIP CO | | | | T | | Y YES 2 NO |
| sit per | ERAL | 6028 Hunt | Ridge | Road | | | | | 212 | | | | | | AT COUNTRY? |
| af-tran | FUNE | 11. MARITAL STATUS | | 12. WAS DECEDE | NT EVER IN | U.S. ARMED | D] | | DECENDENT | OF HISPA | | (Specify Yes | or No- | 14. RACE - | - American Indian, |
| eroung prysician. as the burial-transit permit. Pages | ВУ | 1 Never Married 2 3 Widowed 4 Divo | | FORCES? IF YES, GIVE | WAR OR DAT | TES XINO | | | , specify Cui YES 2 X N | | | Icen, etc.) | | Specify: | white, etc. |
| use as | TEO | | EDENT'S EDU y highest grade | | | (Give I | DENT'S USUA | lone during | ATION most of wor | king | 16b. | KIND OF BU | SINESS/INDU | ISTRY | |
| d for u | COMPLET | 12 years | 1-12) | College (1-4 or 5 | +) | | NOT use retir | , | | | | Orm | Home | | |
| be detache | OMI | 17. FATHER'S NAME (First, M | iddie, Last) | | | 110111 | elliake | L | 18. MC | THER'S N | Own Home AME (First, Middle, Maiden Surname) | | | | |
| at o | ш | John | | Les | ssig | | | | J | ulia | | | (un | know | 1) |
| 5 should | TO B | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | | |
| age 5 | _ | Terrence Michael Finn 25 Dunkirk Road, Baltimore, MD 21212 200. METHOD OF DISPOSITION DATE 200. LOCATION — City of Town. State | | | | | | | | | | | | | |
| director, pa | | 1 Burlet 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland | | | | | | | | | | | | | |
| incare because when z hours arise deam. Fage to may be retained by the hospital to all prycition and completely filled in by the funeral director, page 5 should be detached for use more prior to burial, committing, or removal. The traumatic event, the medical examiner must be notified at once. | | 21. SIGNATURE OF FUNERA | L SERVICE LI | ALAMA | 18 | 21 | | 22. NAM 15.50 | chell O Yor | Wie k Rd | defel Bal | d Home | Ins. | 2121 | 2 |
| ed in by the or removal medical | | 23. PART I. Enter the d | Iseasea, or | complications th | at caused | the deeth | Do not a | | | | | | | | Approximate |
| y filled in filon, or n the mer | | IMMEDIATE CAUSE (Fir disease or condition | | List only one ca | | | diel | | i w.F. | 15.6 | Tim. | | | | Onset and Death |
| ompletely al. crema event, | | resulting in death) | 7 | DUE 1 | (OR AS A | CONSEQUE | ENCE OF): | | DIFC | ے اس | -401 | | | | |
| and cor burial. | NO | Sequentielly list condit | | b. PC.Y | OXY | CONSEQUE | L a | trio | ed fil | rille | Lion | | | | |
| sician prior to | CAT | IMMEDIATE CAUSE (Final disease or condition resulting in death) By Cardial inforction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury C. | | | | | | | | | | | | | |
| n ceruicate be execute and or Hygiene prior to buria or other traumatic | CERTIFICATION | that initiated eventa resulting in death) LAST | | | | | | | | | | | | | |
| the attending Mental Hygie | CER | d | | | | | | | | | | | | | 1 |
| 2 5 5 | DICAL | PART II. Other significa | int condition | na contributing to | o deeth bu | ut not resu | uiting in th | e under | lying ceus | givan ir | Part I. | 24a. WAS AN PERFOR | | A | PERE AUTOPSY FINDINGS |
| signed by the Health and P | DIG | | | | | | | | | | - | 1 TYES | NO | | OMPLETION OF CAUSE IF DEATH? |
| | : WE | DID TOBACCO U | ISE CONT | PIRLITE TO C | ALISE OI | E DEATH | 1 VEC [| T NO | ПШ | CEPTAI | NΠ | | | 1 | YES 2 NO |
| the has the sate Dept em 23 | IAN | 25. WAS CASE REFERRED T | | 1 | | | OF DEATH (C | | | CENTA | 14 🚨] | | | | |
| | /SICI/ | 1 YES 2 NO | | HOSPITAL: Inpetient 2 | ☐ ER/Outpe | atlant 3 🗆 | | HER: Nursing | Home 5 🗆 | Reeldence | 8 Othe | (Specify) | | | |
| 日本日 | ву РНУ | | Pending Investigation | 26a. DATE O (Month, | Day, Year) | 2 | 886. TIME OF INJURY | | . INJURY AT WORK? | □ NO | 28d. DES | CRIBE HOW | INJURY OCC | URED | |
| 5 4 D W | 8 | 3 Suicide 8 | Could not be determined | 28e. PLACE building | OF INJURY g, etc. (Speci | — At home, | , farm, street | , fectory, | offica | | | ATION (Street or Town, State | | or Rural Roo | ite Number, |
| FRAL DIRECTOR: n 72 hours after T: If Item 28 i | COMPLET | anal | | ICIAN: To the best of | | | | | | | | | | | and menner so stated. |
| 13 | | 29b. SIGNATURE AND TITLE | | | Λι | | | | | ICENSE NU | | | | | fonth, Day, Year) |
| SE NO | TO BE | Mi / | WWW. | 10 COMPLETED CAL | - | Si Cica | | | AS. | 2401 | | W 1757 | | | |
| 1 | | ALT N. | TAK | | | | | Ba | (Ein | ore | | | | | |
| | | 31. DATE FILED (Month, Day, FEB 1 3 | 1996 | alla da | ARS SIGN | PRE LANGE | 6 | | | | | | | | |

er meet a till a till

| BALLIMORE, MARTLAND 21213-0020 | hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | or removal. | medical examiner must be notified at once. | |
|--|--|--|--|--|--|
| CIVISION OF VITAL RECORDS, F.C. BOX 667 60 | THE MOSTITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with: hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE RAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: Il Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

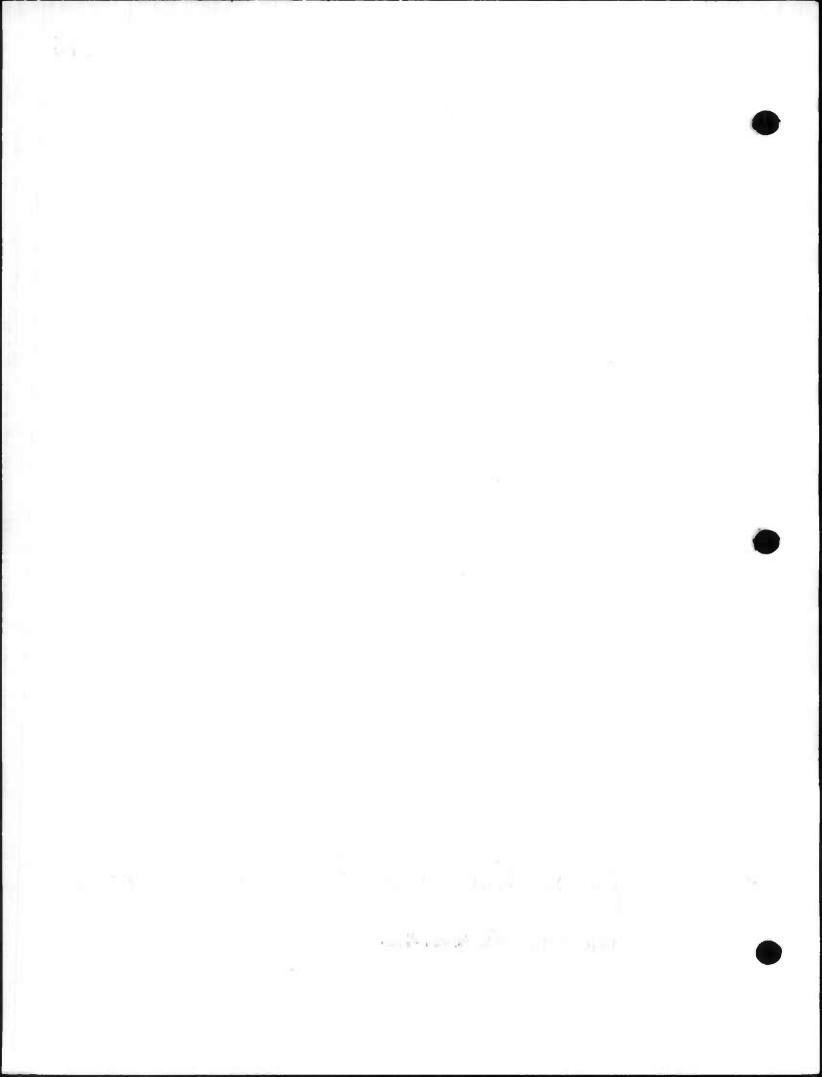
| | | | | | | | | | | 9 | 6 (| 3538 |
|--------------|---|----------------------------|------------------------------------|-----------------------------|---------------------------|---------------|--------------|---|---|-----------|---------------|---|
| | 1 - STATE REGISTRAR | STATE OF N | | DEPAR | | | | | MENTAL HYGIEN | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | C | SKIII | ICAII | E OF | DEAL | ın ı | REG. NO. | | | |
| | | CHOMET | , | | OT THE | | | | MONTH DA | | YEAR | 3. TIME OF DEATH |
| | NANETTE 4. SOCIAL SECURITY NUMBER | CHOMET 5. SEX | B. AGE (In yrs. la: | | OLEY IF UNDER | | | | February | 8,1 | 1996 | 11:10A M |
| | | 1 D M 2 🔯 F | | YRS. | MONTHS | DAYS | IF UNDER | MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | Country | |
| | 216-16-6878 9a. FACILITY NAME (If not institution, give s | Δ. | 87 | ma. | | | | | Aug 16 190 | ~ _ | | York |
| œ | | | | | | | R LOCATIO | | ATH | 9c. CO | UNTY OF DE | EATH |
| ē | 4407 Sedgewick | Road | | | Ba | Ltim | ore (| City | | | N/A | |
| DIRECTOR | 10a. STATE 10b. COUNTY | , | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY |
| E I | Maryland N | /A | | | Ra1 | timo | re C | itu | | | | LIMITS? |
| - | 10e. STREET AND NUMBER | 7 2 1 | | 1 | Dal | | ZIP CODI | | | 100 CI | TIZEN OF W | THAT COUNTRY? |
| FUNERAL | 4407 Sedwick Ro | d | | | | | | | | log. Ci | | THAT COUNTRY! |
| N | ti, MARITAL STATUS | 12. WAS DECEDEN | T EVER IN II C A | PMED | 119 | WAS DEC | | 210 | IC ORIGIN? (Specify Yes | | USA | |
| | t Never Married 2 Married | FORCES? t | YES 2 V | NO | | If yes, sp | ecify Cube | n, Mexicen | , Puarto Rican, etc.) | or No- | | - American Indian, White, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | 1 🗍 YES | 2 X NO | Specify | | | Specif | White |
| G | 16. DECEDENT'S EDU | | | ECEDENT'S | | | | | 16b. KIND OF BUS | SINESS/II | NOUSTRY | WILLEC |
| E | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+ | Ubo | live kind of a. Do NOT u | work done se retired.) | during mo | st of workin | g | 121 NAME - 11 AN- | | | |
| P | Landing years (2-12) | 3 vrs | | iste | red 1 | Nurs | ۵ | | Medica | 1 | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 7 VI.S | 1100 | 1000 | I Cd | NULS | | IER'S NAM | AE (First, Middle, Maiden | | | |
| | Ignetz | | Chome | t | | | To | da | | | 70 | ntz |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | | ADDRES | S (Street a | | | oute Number, City or Town | n State i | | 112 |
| 2 | Dr. Gardner P.H. | Foley S | | | | | | | altimore, | | | 21210 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | | | | | I, Do | | | - City or Tox | |
| | 1 N Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | ovel from State | Druid | matory or o | other place) | omot | 03417 | | 1 | | | · · |
| 1 9 | 21. SIGNATURE OF FUNERAL SERVICE LIC | EMINE | Drard | MIG | | | D ADDRES | SS OF FAC | 2/10 Pike | 2SV1. | me, | Maryland |
| | · Mertin X | Howson | | | | | | | efeld Home | | | |
| _ | Martin D. Nas | #spn | | | 6. | 500 | York | Road | d. Baltimo | re. | Mary? | Land 21212 |
| | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | 200 | | | | | | | | | | Interval Between Onset and Death |
| | disease or condition resulting in death) | Bradyc | ardia | | | | | | | | | 1 Day |
| - 1 | | DUE TO | OR AS A CONSE | OUENCE O | rF): | | | | | | | 1 Day |
| z l | Commentation that consider | Massiv | e strok | e | | | | | | | | 2 Days |
| E | Sequentieily list conditions, if sny, leading to immediate | | OR AS A CONSE | | F): | | | | | | | |
| ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury | - Thromb | ocytosi | S | | | | | | | | 1 Year |
| 片 | that initiated events resulting in death) LAST | DUE TO | OR AS A CONSE | OUENCE O | F): | | | | | | | |
| H | | d | | | | | | | | | | |
| 2 | PART ii. Other significent condition | s contributing to | deeth but not | resuiting | In the ur | nderivino | COUSA C | lven in F | Pert i. 24a. WAS AN | ALITOPEI | V 245 | WERE AUTOPSY FINDINGS |
| MEDICAL | History of part | | | | | | , | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | PERFOR | RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | TEHIL | | | | 1 YES 2 | NO NO | | OF DEATH? |
| Σ | bowel , Coronary DID TOBACCO USE C | Artery | Disease | | DEAT | 71.1 30 | | 110 | _ | | | 1 TYES 2 NO |
| N N | | ONTRIBUTE | IO CAU | ot Or | DEAI | | | NO | □(Unk) | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Che | ck only one) | | | |
| ₹ | 1 VES 2 NO | 1X Inpatient 2 | | | 4 🗆 Nur | | e 5 □ Re | sidenca 8 | B ☐ Other (Specify) | | | |
| ᇤ | 27. MANNER OF DEATH 1 X Natural 5 Pending | 28a. DATE OF (Month, Da | | 28b. TIN | JURY | | RK? | | 28d. DEŞCRIBE HOW II | NJURY O | CCURED | |
| B | 2 Accident Investigation | | | | | | ES 2 | NO | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE Of building, | F INJURY — At ho atc. (Specify) | ome, ferm, | atreet, fac | tory, office | | | 28t. LOCATION (Street a City or Town, State) | ind Numb | er or Rurel R | loute Number, |
| E | TI - Tomicios difficulted | | | | | | | | | | | |
| PL | 29a. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. | | | | | | | | | | | |
| COMPLET | 000 2 MEDICAL EXAMINE | R: On the basis of ex | amination and/or | Investigation | on, In my o | opinion, d | eath occur | ed at the t | lime, date and place, an | d dua to | the cause(s) | end manner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CERTURES | 1 | | | | \rightarrow | 29c. LICE | NSE NUM | BER | 29d. D/ | ATE SIGNED | (Mjorith, Day, Year) |
| 0 | Mr_ (V. | 4Ta | Mil | U | 104 | /. | D. | 477 | 48 | | 2/9 | 196 |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUS | E OF DEATH (ITE | M 27) (No. | Print) | ` ' | 9 | • • 1 | | | - | |

MD 21215

John P. Hakim, M.D., Sinai Hospital of Baltimore, Baltimore,
31. DATE FILED (Month, Day, Year)

72. REGISTRAR'S SIGNATURE

FEB 1 3 1996



Please Type or Print in Black Indelible Ink. Assure All Copies Are Locible State of Maryland / Department of Health and Mental Hygiene 96 03539

| | | | | | | Certificate of | Death | , , | g. No. | | |
|------------|--|--------------------|--|--|-------------------------|--|--|---|--------------------------------|-----------------------------------|---|
| п | Physic | ian | Decedant's Name (First, Middla, La. | sf) | | | | 2. Data of Death Month | Day | Year 3 | 3. Tima of Death |
| | /Medi | | GAIL | WIL | LIAM | FOUCI | HS | FEBRUARY | 7 5, 19 | | 4:07AM |
| | Exami | | 4a. Facility Nama (If not institution, giv | e street and number; | | | 4b. City, Town, or L | ocation of Deeth | 4c. County | of Death | |
| T | | | NORTH ARUNDEL HO | SPITAL | | | GLEN BU | RNIE | ANN | E ARUNI | DEL |
| | Funeral | | 5. Sociel Security Number 8. S | | ga (In yrs. last bir | thdey) if Under 1 Yeer | | 8. Deta of Birth (Month, Day, | Vacal | 9. Birthplace | a (Stata or Foreign |
| в | Director | | 200 12 1205 | ∑ M 2□ F | 68 | Yrs. Months Days | Hours Min. | 11-08-1 | | | /IRGINIA |
| | pu . | | Usual Residence of Decedant 10a. State 10b. County | | 10c. City, Tow | | | | | | |
| | anyta shor | - | | ADIMDET | TOC. City, Tow | | TIE | | | | insida City Limits |
| | the Marylar 28a-f show nothing at | cto | | ARUNDEL | | MILLERSVI | . TILE | | | | 1 ☐ Yes 2 🖾 No |
| | th with | Funeral Director | 10e. Street and Number 656 WEST WHEAT MI | LL COURT | | 10f. Zip Coda 211 | 08 | 10 | g. Citizen of V U.S | What Country? . A . | 1 |
| | Neme | Ine | 11. Meritel Status | 12. Was Decedant Armed Forcas? | Evar in U,S. | 13. Was Dacedent of I If Yes, specify Cub | Hispanic Origin? (Sp | ecify Yas or No- | | e - Amarican I ck, White, atc. | ndlen, |
| 20 | or in | by Fu | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 1- Yes 2□ If Yas, Giva | No 1949- | 1□ Yas XXX No | | , , , , , , , , , | Specify | | |
| 21215-0020 | 72 hours natural, | 8 | 15. Decedent's Ed | Yaar or Datas: | 1973 | Decedent's Usual Occur | | | D 165-1-15 | | |
| 15 | n 72 | Completed | (Specify only highast gra | da completed) | | (Giva kind of work dona lifa. DO NOT usa retire | during most of work | ting 1 | 60. Kind of Bi | usinass/Indust | ry |
| 12 | within ene. | E | Elemantary/Secondary (0-12) | Collega (1-4or | | | , | | anav d | ODD OD | ENGINEER |
| | Il Hygid other | | 12 17. Father's Neme (First, Middle, Last) | 2 | <u>F</u> | NGINEER | 18 Mother's Nem | e (First, Middle, M | | | ENGINEER |
| Maryland | 2 should be fi and Mental H Is marked off surratic ever | To Be | SHIRLEY N | | FOUCHS | | EFFIE | M . | | LLOTER | |
| N N | should by and Menta marked imatic ev | - | 19e. Informant's Name/Raletionship (| | | . Mailing Addrass (Street | | | | | del |
| X | | | CLARICE J. FOUC | | | 56 WEST WHE | | | | | |
| ē, | other tr | | 20a. Mathod of Disposition | | 20b. Place of | Disposition (Nama of | | | | City or Town, | |
| DO | 6 6 ···· | | XBurial 2 □ Cramation 3 □ | | | y, crematory or othar pla | 12 | /16 | | | |
| Baltimore, | permit. Page Department of Important: If any Injury or ance. | | 4 Donation 5 Other (Specify | <u> </u> | WILLAM | ETTE NATION | | | | D, OREC | JON |
| Ba | mpo mpo my l | | 21. Signature of Funerel Sarvice Lican | 500 | | 22. Nama and Addra | ass of Facility SIN | NGLETON F | UNERAL | HOME | |
| | | | 23a. Part . Enter the diseast, or companoot, or heart failure. List only | Hecken | | 1 SECOND A | | | | ,MARYL | AND 21061 |
| | Physician /Medical Examiner | ner | Immediate Cause (Final disass or condition rasulting in daath) | a. Ver | Dua to (or as a | | inenc | ωχυρ | | 2 | -5-fl |
| Box 68760, | certificate be executed nding physician and use as the burlel-transit | n/Medical Examiner | Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last | b | Due to (or as a c | consequence of): | Caraco | myop | 3 | | |
| m | death cert e attendin id for use | cla | Part II Other significant annultings | and allowations do allowable by | unt mant man subblem to | At a section of the section of the | to Book | aab Didas | | - A-10 | |
| P.0 | the the | y Physician/M | Part II. Other significant conditions or | ontributing to death b | ut not rasulting in | i the undariying causa gr | van in Part I. | | | 3 Probabl | y 4 daknown |
| Records, | ew requires to seen s | Completed by | | | | | | 24e. Wes an perform | | availab | autopsy findings ble prior to ation of cause th? |
| = | Pag at | S | | | | | | ☐ Yas | 2 No | (DYs | 2 □ No |
| Vital | ysician: The s certificate director, pag | Be | 25. Was casa rafarred to medical axaminar? | | | | | h (Check only one |) | | |
| of | 5 00 | 2 | 1 Yes 2 No | Hospital: | nt 2□ER/Ou | tpatient 3□ DOA Oti | har: 4 Nursing Ho | oma 5 □ Rasider | nce 8 Oth | ar (Specify) | |
| | | | 27. Mannar of Deeth 1 ☑Naturel 5 ☐ Pending | 28a. Data of Inju (Month, Da | | ima of 28c. Inju | ry at | 28d. Describe how | w injury occur | red | |
| Ö | Attending r deeth. ector: After by the fune | atic | 2 Accidant investigation | | / | | Yes 2 □ No | | | | |
| | P Str | ertification: | 3 Suicida 6 Could not be 4 Homicida determined | 28a. Place of Inj building, at | | rm, street, factory, office | | 28f. Location (Str. City or Town, | | er or Rural Ro | ufa Number, |
| (| Hospital Schours Ameral | edical C | 29e. Certifiar (Check only one) | ysician: To the best iner: On the basis of and mannar st | examination and | , daath occurred at tha tid d/or invastigation, in my | ima, data and placa, opinion, daath occur | and due to the car red at tha time, de | use(s) and ma ta and place, | nnar as stated and due to the | d. cause(s) |
| 1 | 56.0 | Me | 29b. Signatura and title of certifiar | _ / | | 29c, Licans | sa number | 29 | d. Dete signe | d (Month, Day | , Year) |
| | | | | // | | /: 0 | 102-1 | 2 | 21 | 1.0 | 1 |
| | M | 1 | 30. Name and address of parent who | vomelottel annua af | leath (Ita = 00c) | Turne Briefl | 1000 | | 116 | 11/ | |
| | | | 30. Nama and address of person who c CHARLES J. W | U W.D. | 1600 | Type, Print) S.CRAIN H | WY. GLEN | N BURNII | E 2106 | 1/ 6 | |
| | Sta | 10 | 31. Data filed (Month, Day, Year) | 32, Registr | ars Signature | | | | 2100 | , 1. | |
| | Sta | 10 | | Die A | | | | | | | |

playing the grant of the grant

TO THE HOSPITAL OR ATTEMENT TO COME. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, at item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION DE VITAL RECORDS, P.O. BOX 68760

| | 1 - STATE REGISTRAR | STATE OF MARY | LAND / DEPAR CERTIF | | | | MENTAL | HYGIENE REG. NO. | | | | | |
|---------------|--|---|---|--|--------------------|---------------------------|----------------------|-------------------------------------|--------------------------------|------------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Blanche I | MONTH DAY VEAR | | | | | | | 5-20 M | | | |
| | U | | E (In yrs. last birthday) | IF UNDER 1 | | F UNDER 24 HRS. OURS MIN. | 7. DATE ((Month, | OF BIRTH Day, Year) | | 8. BIRTHPI Country) | ACE (State or Foreign | | |
| | 242-24-7148 Se. FACILITY NAME (If not institution, give street | | 72 YRS. | 9b. CITY, T | TOWN OR I | LOCATION OF DE | | /1923 | | NORT | H CAROLINA | | |
| TOR | MERIDIAN NURSING C | ENTER | | SEVE | RNA I | PARK | | | ANNE | ARU | NDEL | | |
| DIRECTOR | 10s. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR | LOCATION | ч | | | | 1 | 0d. INSIDE CITY LIMITS? | | |
| | MARYLAND ANNE AR | UNDEL | GLE | N BURI | | P CODE | | Т | 10a. CITIZ | | YES 2 NO | | |
| FUNERAL | 306 GLENWOOD AVENUE | , | | 21061 | | | | | U.S | | | | |
| BY FUN | 11. MARITAL STATUS 12 1 Never Merried 2 Merried 2 Werried 3 Widowed 4 Divorced | P. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | YES 2 XNO If yes, specify Cuban, Mexica | | | | | | - American Indian, White, etc. | | | | |
| TED | 15. DECEDENT'S EDUCAT (Specify only highest grade con | | 18e. DECEDENT'S | work done du | | of working | 16b. | KIND OF BUSI | NESS/IND | USTRY | WILLEL | | |
| COMPLETED | | College (1-4 or 5+) N/A | HOMEMAI | | | | | OWN HO | ME | | | | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | | | | 10 | 8. MOTHER'S NA | ME (First, M | iddle, Maiden S | umame) | | | | |
| BE | JAMES V. | | PENNY | ADDRESS / | (Stand and | ZULA | Onuto Atumb | JOHNS | | Codel | | | |
| 6 | Johnni Johnie L. Fetty | e L. Fetty | / | | | | | N BURNIE, MARYLAND 21061 | | | | | |
| | 20s METHOD OF DISPOSITION 1 A Jaurial 2 Cremetion 3 Remova 4 Donation 5 Other (Specify) | I from State | Ob. PLACE AND DATE emetery, crematory or of GLEN HAVE | of Disposition of Dis | ORIAI | PARK | 2/5 | 20c. LOC | ATION — O | NIE. | n, State MARYLAND | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE SEE | | | | ADDRESS OF FA | | | | | L HOME E, MD 21061 | | |
| | shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| CERTIFICATION | Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in death) LAST | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| MEDICAL | PART II. Other algorificant conditions of CHRONIC DIANSETES | | | - Charles | leriying c | euse given in | Part i. | 24a. WAS AN / PERFORM 1 YES 2 | AED? | | WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| | DID TOBACCO USE CONTRIB | SUTE TO CAUSE | OF DEATH Y | ES 🗆 N | 10 🛮 | UNCERTAI | NE | • | | | YES 2 NO | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | 26. PLACE OF DEA | TH (Check on | nly one) | | | 4230 | | | | | |
| HYS | 27. MANNER OF DEATH | 26e. DATE OF INJUR (Month, Day, Year | IY 28b. TIN | | 28c. INJUR WORK | 5 Realdence | × · | (Specify) CRIBE HOW IN | JURY OCC | CURED | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | IRY — At home, lerm, | М | 1 YES | 3 2 NO | | | | | | | |
| TED | 3 Suicide 8 Could not be determined | building, etc. (S | pecify) | street, ractor | ry, ornice | | | ATION (Street ar or Town, State) | nd Number | or Humii Ho | ute Number, | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL (Check only one) 2 MEDICAL EXAMINER: | | | | | | | | | | end manner as stated. | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER ATTENDING 29c. LICENSE NUMBER 29d. DATE SIGNED (Morrith, Day, Year) 21219 | | | | | | | | | | | | |
| 0 | 30, NAME AND ADDRESS OF PERSON WHO CO | | DEATH (ITEM 27) (Type | , Print) | - 81- | TAP. | | Av. | 27 | CTLA | n ME 2122 | | |
| | FFR 1 3 1996 | 32. REGISTRAR'S SI | | | | | | | | | | | |

and the second

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| | | | State of Maryland / Department of Health and In | | eg. No. | b (| 13341 |
|--------------------------------|--|--------------------|---|--|-----------------------------|-------------------------------------|---|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, Last) GEORGE C. GRANVILLE, SR. | 2. Date of Deer Month Ebluak | th Day 77 | Year 1996 | 3. Time of Death |
| | Examile Funerale Director | | 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or L | ocation of Death MRE 8. Date of Birth (Month, Day) | 4c. County | 9. Birthol | ace (State or Foreign try) |
| | D | tor | Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Maryland Anne Arundel Brooklyn Park | Aug. 1 | 1,1930 | | /land Od. Inside City Limits 1 □ Yes 2XI No |
| | th with the 23e or 28 ast be not | Funeral Director | 10e. Street and Number 10f. Zlp Code 21225 | | og. Citizen of V United | | * |
| 020 | n 72 hours effer death with the Marylend "natural", or frema 23s or 28s-f show solical Examiner must be notified at | þ | 11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever In U.S. Apped Forces? 13. Wes Decedent of Hispenic Origin? (Sr If Yes, specify Cuben, Mexican, Puerto Yes, Give 1954–58 14. Wes Decedent of Hispenic Origin? (Sr If Yes, specify Cuben, Mexican, Puerto Yes or Dates: 1954–58 | pecify Yes or No- Rican, etc.) | Biec | e - America k, White, c White | etc. |
| Baltimore, Maryland 21215-0020 | | Completed | 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) 12 15. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired) Steamfitter | king | 16b. Kind of Bu | al #4 | |
| and | Mental Hygi Mental Hygi arked other atic event, to | Be | 17. Fether's Neme (First, Middle, Lest) George C. Granville E | e (First, Middle, I leanor | Meiden Surnem | e) Esl | er |
| Maryl | 2 sh and is m | To | 19e. Informant's Name/Reletionship (Type, Print) Mr. George C. Granville, Jr. 19b. Malling Address (Street and Number or Ru. 809 Cedar Branch Drive | rai Route Number | , City or Town, | | |
| imore, | 9 2 4 > | | 20b. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other piece) Metro Crematory, Inc. 2, | | 20c. Location - Baltimon | | wn, State aryland |
| Balt | permit. Pe Departmen Important: eny injury | | 21. Signature of Funeral Service Upages 22. Name end Address of Facility MC Cully Funeral Ho | ome of B | rooklyn | e, ME | 21225 |
| Contract of the last | Physician /Medical Examiner | ner | 23a. Pert1. Enter the present of composations that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) a. ACUTE MYOUADDIAL INFARCATION Due to (or es a consequence of): WEFETTEN 15 N | |)St, | | Approximate Interval Between Onset and Death |
| Box 68760, | The lew requires that the deeth certificate be executed ate hes been signed by the ettending physician and page 2 should be deteched for use as the burtel-transit | n/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | |
| Ö. | that the deeth cer ed by the ettendin deteched for use | Physician/M | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did to | bacco use cor | tribute to | the cause of death? |
| S, G, | res that the igned by be detected | by | PEPTIC ULCER DISEASE | 1 🗆 Y | es 2□ No | 3 ☐ Prob | ebly 4 ☐ Unknown |
| Record | e lew require hes been si ge 2 should | Completed | | 24a. Wes a perform | | eva | re autopsy findings illeble prior to appletion of cause leath? |
| Vita | certificate he | Be Co | 25. Was case referred to medical 26. Placa of Deal | 1 TY | | 1 🗆 | Yes 2 No |
| ot < | Physics this ca | ပ္ | | ome 5 Reside | | |) |
| Melon | or the John | Certification: | 27. Menner of Death 1 Netural 5 Pending investigetion 3 Suicide 4 Homicide 28a. Dete of Injury (Month, Dey Year) 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury the Work? M 1 Yes 2 No 28c. Injury et Work? 1 Yes 2 No 28c. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) | 28d. Describe ho | reet and Numb | | Route Number, |
| ۵۱ | Hospitario 24 hours and Funeral Di stely filled in | edical Cer | 29a. Certifler (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur | and due to the ca | suse(s) and me | nner as sta | ated. the cause(s) |
| | To the Hospit within 24 hour To the Funer completely fin | Me | 29b. Signature and title of certifier 29c. License number | 4-46 | 9d. Date signed | (Month, L | Pey, Year) |
| _ | | | 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) TAHAR SATTAD MD HARBOR HOSPITAL CENTER 3 | 001 S. H | ANOVER | ST | BALTO ND. |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. | | | | 12122 |

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the second secon

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State of Maryland / Department of Health and Mental Hygiene Q C

| | | | Decedant's Name (First, Middla, L | ast) | - | Cer | tificate | or . | Death | 2. Dete of Dec | Reg. No. | T | 3. Time of | f Death |
|---------------------|--|--------------------------|---|--|---------------------------------|------------------------------|---------------------------|------------------|---|--|-----------------------------------|------------------------------|--|---------------|
| | Physic | | Robert G. | Garcia | | | | | | Month 2 | Dey 8 | Yaar 96 | 4:3 | 38 A.M |
| | /Medi Examir | | 4a. Facility Name (If not Institution, g | |) | | | | 4b. City, Town, or I | ocation of Death | | | - | 71.70 |
| | 2,00 | | 1935 E. Balt | imore St | imore Street Balti | | | | | | | | | |
| | Funeral | | | Sex 7. A | | last birthday) | If Undar Months | 1 Yaar Days | If Undar 24 Hrs. Houra Min. | 8. Data of Birt (Month, De | h Year) | 9. Birthple | ca (Stata c | or Foreign |
| н | Director | | 215-14-8727 | 1 ⊠ M 2□ F | 72 | Yrs. | MOTITIO | Days | Tiodia Iviii. | 08/10 | /1923 | | York | |
| | P * | | Usuel Residence of Decedent 10a, Stete 10b, County | | 10c. Ci | ty, Town or Lo | cation | | | | | 100 | d. Inside Ci | ity I imits |
| | Marylar f show led at | 0 | MD | | | ltimo | | | | | | | 1 TYas | |
| | the Man r 28a-f sh notified | Director | 10e. Street end Number | | | | 10f. Zip | Code | | | 10g. Citizen of | What Countr | v? | |
| | Sa or | ie D | 1935 E. Baltin | nore Stre | eet | | | 21 | 231 | | | SA | | |
| | dead f.m. | Funeral | 11. Meritel Stetus | 12. Was Decedent | Evar in U | J,S. 13. V | Vas Decede | | Ilspanic Origin? (S an, Mexican, Puert | pecity Yas or No- | 14. Rec | ce - Amarica | n Indien, | |
| Maryland 21215-0020 | ours after of, or its Examine | þ | 1 ☐ Naver Married 2 反 Merriad 3 ☐ Widowed 4 ☐ Divorced | tried Forcas tried Yes 2 ☐ If Yes, Give Yeer or Datas: | | | Yes 2 | | | o Hican, etc.) | Specif | ck, White, et y: White | | |
| 3 | 72 h natur fical | Completed | 15. Decedent's E (Specify only highast g | ducation | | 16a. Deced | lent's Usuel | Occup | ation during most of wor d) | kina | 16b. Kind of B | uainass/Indu | istry | |
| 2 | Man No. | du | Elementery/Secondary (0-12) | Coilega (1-4or | 5+) | | | | | Amy | Colum | bia N | lovir | ng |
| 12 | hard w | ဒီ | 10th | | | Move | c & F | ₹ig | | | & Rig | | | |
| and | Vid be fi Vental F rked of tic ever | Be | 17. Father's Nama (First, Middle, Las | • | | | | | 18. Mother's Nen | 11.10.00 | Meidan Surnar | na) | | |
| ž | 0 - 0 - | 10 | Robert Garcia 19e. Informent's Name/Reletionship | | | 10h Mollie | a Addross | /Ctract | Carrie | 1 n K | City of Town | State Time! | Sardal . | |
| Ma | and 2 shy alth and 27 is ma er fraum | | Francine Road | W | lfe | | _ | | 1timore | | | | , | 2123 |
| re, | 1 1 ar 1 Hoo Men 2 other | | 20e. Method of Disposition | M Garcia | 20b. I | Pleca of Dispo | sition (Nem | e of | | Dete | 20c. Location | | | . 1 2 0 |
| Saltimore, | Page ent o ht: III I | | 1 ☑ Buriei 2 ☐ Crametion 3 I 4 ☐ Donetion 5 ☐ Other (Spec | | | cemetery, cren | | | t Vet. | 2/13/9 | 5 Bal+ | o Ma | 4 | |
| att | mit. I partm portar r inju | | 21. Signeture of Funerel Service Lice | | / | | | | ss of Fecility JO | | | | | Э.Н. |
| <u> </u> | Deps Impo any i | | yrene h | Zannes | / | _ 2 | 263 S | S. (| Conklin | g St. I | Balto. | Md. | 2122 | 24 |
| | Physician /Medical | | 23a. Pert1. Enter the disease, or conshock, or heert feilure. List only Immediate Cause (Final disease or condition | one cause on each | | | | | farction | or respiratory ar | rast, | - 1 | Approximate nterval Bet Onset end I | ween Deeth |
| | Examiner | | resulting in deeth) | a | Due to (| or es e conseq | uence of): | -// | 1001 | | | | ii iiy equi | are. |
| | R # | Examiner | | h | At | herosci | lero ti | 6 6 | coronary | artery | disease | | immedi >5y | ears |
| | and | хап | Sequentially list conditions, | | | or es e conseq | | | | | | | | |
| 68760, | ificete be executed g physician and as the bunal-transit | | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | | i | | |
| 687 | phy: | edical | resulting in deeth) Last | | Due to (c | or as a consequ | uance of): | | | | | - | | |
| Box | | 2 | | d | | | | | | | | | | |
| | the death cer y the attendin sched for use | icia | Part II. Other algnificant conditions | contributing to death I | out not res | ulting in the ur | deriving ca | use niv | en in Pert I | 23h Did I | obacco use co | ntribute to t | he cause (| of death? |
| P.O. | | Completed by Physician/M | | | | and an area | idonying ou | udo giv | | | Yes 2□ No | 3 Probe | | Unknow |
| Vital Records, | w requires that been signed b should be deta | eted b | | | | | | | | | en autopsy med? | avail | e autopsy f leble prior t pletion of c | to |
| 3ec | hes b | jdu | | | | | | | | | | of de | eath? | |
| a | cata he | | | 1 | | | | | | 101 | es 20 No | 10 | Yes 2 | No |
| = | Physician: The lav this certificata hes ral director, page 2 | Be | 25. Wes case referred to medical exeminer? | Hospitel: | | | | Oth | | th (Check only o | | | | |
| ō | Phys ral di | . To | 1 ☐ Yas 2 ☑ No 27. Menner of Death | 1 LI Inpati | | ER/Outpetien 28b. Time of | | ~ | 4 LI Nursing H | ome 5 Resid | | | | |
| on | ding th. After | tion | 1 Neturel 5 Panding 2 Accident investigation | 28a. Dete of Inju | y Year) | Injury | M | Bc. Injur Wor | k? Yes 2 □ No | Edd. Describe i | iow injury occur | | | |
| Division of | f or Attending effer death. Director: After I in by the fune | Certification: | 3 Suicide 6 Could not l | | 28t. Location (S City or Tow | | ber or Rural | Route Num | iber, | | | | | |
| | To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | Medical C | 29e. Cartifier 1 Certifying P (Check only one) 1 Medical Exa | nysician: To the best minar: On the basis of end menner si | of examine | owledge, deeth | occurred e estigetion, | t the tin | ne, dete end place plnion, deeth occu | , and due to the or rred et the time, o | ceuse(s) end m dete end plece, | anner ss sta and due to t | ted. he cause(s | 5) |
| | within 2 To the comple | Me | 29b. Signeture end title of certifier | | | | 29c. | Licens | e number | | 29d. Date signe | ed (Month, D | ey, Year) | |
| | | | > Marl | eller | | | | D | 35363 | | 2/8 | 196 | | |
| _ | | - | 30. Name and address of person who | completed cause of | deeth (Iter | n 23a) (Tyne I | Print) | | | | | | | |
| | 0 | | Sandra Mar | chell | | 1AMC | IO A | 1.6 | reene St. | R. 111 | Md | 2120 | 1 | |

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DELET A LOS

| 020 | nheirian |
|-----------------------|--|
| , MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician |
| JD 21 | nental or |
| YLAP | hy the h |
| MAR | e refained |
| BALTIMORE, | 6 may h |
| Σ | h Pane |
| BAL | fine deat |
| _ | hours a |

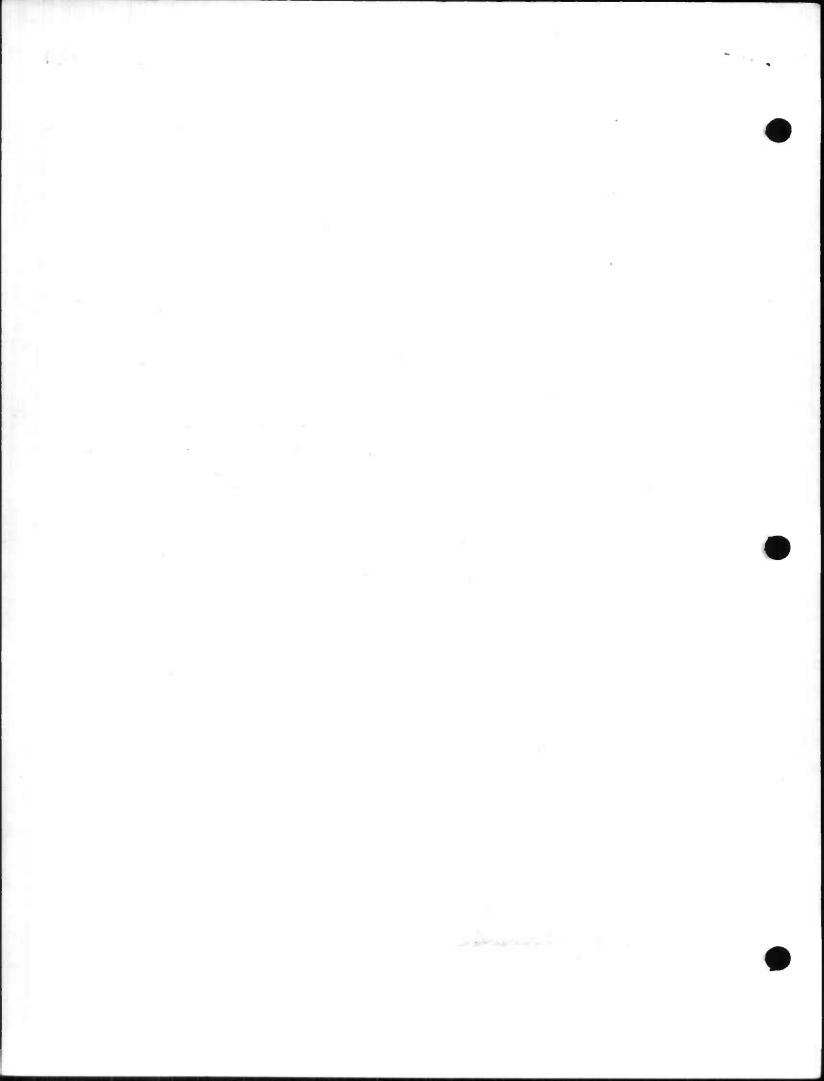
DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO ME HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competes

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|--------------------------------------|---|----------------------------|
| ECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH |

| | 1 - STATE REGISTRAR | STATE OF N | IARYLAND | / DEPAR | TMENT ICATE | OF DEA | AND N | MENTAL HYGIE REG. N | | | | | |
|------------------------|--|---|-----------------------------------|----------------|----------------|--|-------------|--|--|--|-----|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | "Helen F | rances | Gong | loff | | | 2. DATE OF DEATH MONTH February | DAY 10 10 | year 4:15 PM | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER | YEAR IF UNDE | R 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) | n | | |
| | 160~20~8546 Da. FACILITY NAME (If not institution, give | 1 M 2X F | 70 | YRS. | | | | May 29.1 | | Pennsylvania | a | | |
| E . | | | 1: 0 | 044 | | TOWN OR LOCAT | | | | ITY OF DEATH | | | |
| 2 | Johns Hopkins RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | | raical | | | Baltimo | re C | cty | 1 0 | I/A | | | |
| DIRECTOR | Maryland 106. COUN | Baltimor | 10 | 10c. CIT | Y, TOWN O | DUM | dalk | | | 10d. INSIDE CITY LIMITS? | | | |
| | 10a. STREET AND NUMBER | Buccanon | | | | 101. ZIP COC | | | 10g. CITIZ | 1 _ YES 2 _ NO | | | |
| FUNERAL | 5605 Woods Park | way Apt. 3 | 3 A | | | | 2 | 21222 | | ted States | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDEN' FORCES? 1 IF YES, GIVE W | T EVER IN U.S. YES 2 VAR OR DATES | ARMED | 11 | AS DECENDENT yes, specify Cub YES 2 NO | an, Maxican | C ORIGIN? (Specify), Puerto Ricen, etc.) | es or No— | 14. RACE — American Indian, Black, White, atc. Specify: White | | | |
| 8 | 15. DECEDENT'S EC (Specify only highest gra | OUCATION de completed) | 16a. | DECEDENT'S | USUAL OC | CUPATION iring most of work | ina | 16b. KIND OF B | USINESS/INDU | | | | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 + | | Cook | se retired.) | ring most of work | riy | tood | 7.7.4 | 4 | | | |
| at once. | COOK FOOD INDUSTRY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | _ | | |
| 76 III | u∥ Albert Rosmus Mary Holoto | | | | | | | | | | | | |
| TO BI | 19a. INFORMANT'S NAME (Type/Print) Elmer L. Casto | | | | | | | oute Number, City or R | | Code) | | | |
| 8 | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of | | | | | | | | | | | | |
| must | 4 Donation 5 Other (Specify) Canal Figure 1 Canal Fill Cemetery 2/13/1996 Baltimore, Maryland | | | | | | | | | | | | |
| or removal. | 21. SIGNATURE OF FUNERAL SERVICE I | ICENSEE | | | Du 0 | ame and addre | Fune | ral Home Dundalk | of Dun | idalk. Inc. | | | |
| or removal | 23. PART i. Enler the diseases, or shock, or heart feliure | complications that | caused the | death. Do r | of onton | ha mada at di | In a such | 41 | Contract of the Contract of th | 1 | | | |
| r, cremation, or | iMMEDIATE CAUSE (Final disease or condition resulting in death) | a. acute | Puls | nma | y Eel | ema, c | mil | heart for | lin | interval Betwee | | | |
| matic e | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | ling to Immediate | | | | | | | | | | | |
| or other | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 는 를 | PART ii. Other aignificent condition | | | t resulting | in the und | erlying cause | given in P | | N AUTOPSY | 24b. WERE AUTOPSY FINDIN | IGS | | |
| shows any in MEDICAL | Dialiete Hx 2 at | mellity | Irella | tim | | | | I YES | 2 NO | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | E | | |
| | DID TOBACCO USE CON | TRIBUTE TO CA | | | S 🗆 N | | ERTAIN | | | | | | |
| r Item 23 s | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | , | ACE OF DEAT | OTHER | | 225 11 11 | 1_ = 5000 550 | | | | | |
| £ 0 ≧ | 27. MANNER OF DEATH | 1 □ Inpatient 2 28a. DATE OF | INJURY | 28b. TIM | E OF | 8c. INJURY AT | | 28d. DESCRIBE HOW | INJURY OCCI | URED | _ | | |
| s marked, BY PH | 1 Natural 5 Pending Investigation | (Month, De | ly, Year) | INJ | M | WORK? | □ NO | | | | | | |
| 28 1s | 3 Suicide 8 Could not be detarmined | 28s. PLACE Of building, | FINJURY — At Interest (Specify) | home, larm, s | treet, lecto | y, office | | 28f. LOCATION (Stree City or Town, Stat | t and Number o | or Rural Route Number, | | | |
| | | SICIAN: To the best of | | | | | | | | od, cause(s) and menner as ataled. | J. | | |
| IMPORTANT: 1 O BE CON | 29b. SIGNATURE AND TATE OF CERTIFIE | Moldo | mi | | | | O 21 | | 29d. DATE | SIGNED (Month, Day, Year) | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) ATACLLAH GOLPIRA, MD. 3029 Dundalkave, Bullmone, Md. 21222 | | | | | | | | | | | | |
| | FEB 1 3 1996 | 32. REGISTRAL | R'S SUNATURE | \$ | | | | | | | | | |

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|---------------------------------------|---|----------------------------|
| DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH |
| STEPHANIE | GRANT | MONTH DAY |

| 1 - STATE REGISTRAR | SIAIE UP I | MAKYLAND / | ERTIF | | | | | VIEN IA | REG. NO | | | | | |
|--|--|---------------------------------------|-----------------------------|---|--------------|---------------------|------------|------------------|---------------------------------|-------------------|-----------------------------|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) |) | CDAM | | | | | | 2. DATE | OF DEATH | DAY, / | YEAR | 3. TIME OF DEATH | | |
| STEPHANIE 4. SOCIAL SECURITY NUMBER | 5. SEX | GRANT 8. AGE (In yrs. tes | ne hiseholmsk | er UNDE | R 1 YEAR | IF UNDER | 24 1400 | FE | OF BIRTH | 4 | 96 | PLACE (State or Foreign | | |
| 218-76-0718 | 1 M 2 XF | 35 | YRS. | MONTHS | DAYS | HOURS | MIN. | | 28/196 | 50 | County | RYLAND | | |
| Se. FACILITY NAME (If not institution, give | | | | 9b. CIT | y, town (| R LOCATE | ON OF DE | | 20, 250 | | 9c. COUNTY OF DEATH | | | |
| MERCY STELLA MAR | RIS | | | | BALT | IMOR | E | | MORE | | | | | |
| RESIDENCE OF DECEDENT 10s. STATE 10b. COUNT | TY | | 10c. CITY, TOWN OR LOCATION | | | | | | | 10d. INSIDE CITY | | | | |
| MERCY STELLA MAR RESIDENCE OF DECEDENT 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE | LTIMORE | | | | TIMO | | | | | LIMITS? | | | | |
| | | | | | 101 | . ZIP CODI | | | | 10g. CIT | IZEN OF W | VHAT COUNTRY? | | |
| 10e. STREET AND NUMBER 4000 WOODRIDGE R 11. MARITAL STATUS 1 V Never Merried 2 Merried | | | | | | 212 | | | | | | S.A. | | |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? | T EVER IN U.S. AF | RMED NO | (f) the constitution Mayteen Durate Blanc stall | | | | | | | 14. RACE Black Specif | | | |
| 15, DECEDENT'S ED (Specify only highest grad | | 16e. DE | ECEDENT'S | USUAL C | CCUPATIO | ON at of working | 107 | 168 | . KIND OF BU | JSINESS/INI | DUSTRY | | | |
| 15. DECEDENT'S ED (Specify only highest grac Elementery/Secondary (0-12) 12 12 17. FATHER'S NAME (First, Middle, Leet) | College (1-4 or 5 | life | . Do NOT u | se retired.) | | or or working | ·w | | | 110145 | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) | U | - | HOME | MAKE | :R | 10 MOY | HERIO NA | ME /Fint | Middle, Meide | HOME | - | | | |
| | | | | | | 100 | RTHA | | ANT | n Sumeme) | | | | |
| 190. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRES | S (Street a | nd Number | or Rurat I | Route Num | ober, City or To | wn, State, Zi | o Code) | | | |
| MAKIHA GRANI | | | | | | | OAD | | | | | D 21229 | | |
| 20s. METHOD OF DISPOSITION 1 Å Burlet 2 □ Cremation 3 □ Red 4 □ Donation 5 □ Other (Specify) | movel from State | 20b. PLACE. | ometons or s | that place | 1 | | v 0./ | DAT | 17.7 | OCATION — | | | | |
| | ARBUTUS MEMORIAL PARK 2/9/96 ARBUTUS, MARYLAND 21. SECHATURE OF PUREAL SERVICE LICENSEE 22. SECHATURE OF PUREAL SERVICE LICENSEE 22. SECHATURE OF PUREAL SERVICE LICENSEE 22. SECHATURE OF PUREAL SERVICE LICENSEE | | | | | | | | | | | | | |
| 1 2011 | m | | | ' | | | | | | | | ARYLAND 2121 | | |
| 23. PART I. Enter the diseeses, or | complications th | caused the de | eath. Do | not ente | | | | | | | | ARTLANU ZIZ | | |
| shock, of heart failure iMMEDIATE CAUSE (Finel | . Liat only one ce | use on each line | в. | | | | | | | | | Interval Between Onset and Death | | |
| disease or condition resulting in death) | resulting in death) e | | | | | | | | | | UNKNOWN | | | |
| | DUE TO | (OR AS A CONSE | | | , . | | | | | | | Chrisona | | |
| Sequentielly list conditions, | b. DUE TO | HIV OF AS A CONSE | | | 100 | , | | | | | | COVANONN | | |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | G | | | | | | | | | | | | | |
| that initieted events resulting in death) LAST | DUE TO | (OR AS A CONSE | OUENCE C | F): | | | | | | | | | | |
| Sequentielly list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | d | | | | | | | | | | | 1 | | |
| PART II. Other algnificant condition | ons contributing to | deeth but not | resulting | In the u | nderlyin | g ceuee | given in | Part I. | 24a. WAS A PERFO | N AUTOPSY | 240. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| <u> </u> | | | | | | | | _ | 1 TYES | 2 NO | | COMPLETION OF CAUSE OF DEATH? | | |
| DID TOBACCO USE CON | TDIDLITE TO C | VIISE OF DE | ATLI V | EC | NO E | T LINE | CDTAI | | 1 | | | 1 TYES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL | TRIBUIL 10 C | | CE OF DEA | | | 7 0146 | EKIAH | <u> </u> | L | _ | | | | |
| EXAMINER? | HOSPITAL: | ☐ ER/Outpatient 3 | 3 DOA | OTHE | | e 5 □ R | sidence | 6 💢 Oth | er (Specify) | HOSPI | CE | AT MERCY | | |
| | 28e. DATE O (Month, | F INJURY Day, Year) | 26b. TIR | _ | 28c. IN. | URY AT | | | SCRIBE HOW | | | | | |
| 1 Natural 5 Pending 2 Accident Investigation | | | | М | | YES 2 | NO | | | | | | | |
| 3 Suicide 8 Could not be 4 Homicide determined | e building | OF INJURY — At he , etc. (Specify) | ome, ferm, | etreet, fec | ctory, offic | • | | 281. LOC City | CATION (Street or Town, Stet | t end Numbe 9) | r or Rural F | Route Number, | | |
| 29e. CERTIFIER (Check pale CERTIFYING PHY | SICIAN: To the best of | f my knowledge d | eath occur | red at the | time date | and place | and due | to the co | wee(e) and m | anner ee ste | rtad | | | |
| Control only | | | | | | | | | | | | s) end manner se stated. | | |
| 29b. SIGNATURE AND TITLE OF CERTIFI | ER | 0.1. | | | | 29c. LIC | ENSE NUI | MBER | | 29d. DA | TE SIGNED | (Month, Day, Year) | | |
| 20 NAME AND ADDRESS OF BERSON W | men | | | | | | DZ | 1048 | 0 | 10 | ken. | 5 1996 | | |
| 30. NAME AND ADDRESS OF PERSON W | , por | ISE OF DEATH (ITE | - | 9, Print) | ć | 5810 | | | | RD | 9 | | | |
| 31. DATE FILED (Month, Day, Year) | | AR'S SIGNATURE | MD | | | BAT | 10. | n | 0 7 | 2120 | 6 | | | |
| FFR1 31996 Ju | divoler | Redell | | | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene G-732 2/13/96 t.t Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey 1996 February 04, 1996 **Physician** 8:00 P.M. Maru GRAY-Valentine Ann /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner Franklin Square Hospital Rossville Baltimore County If Undar 1 Yaer | If Undar 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1□M 2X F Months Yrs Director 216-01-4253 76 Aug. 24. 1919 Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23a by Funeral 1905 Monroe Road 21222 United States filed within 72 hours after death 11. Marital Status 12. Wes Decedant Evar in U,S. Armed Forces? 14. Race - Amaricen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Detes: ò 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorcad "natural". Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Media 2016. Elementery/Secondery (0-12) College (1-4or 5+) years Meat Cutter Food Industry 17. Fethar's Neme (First, Middle, Last) 18. Mother's Nema (First, Middla, Meidan Sumama) John Doemling Henrietta Rahnis 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret Ponder 701 Silver Avenue Baltimore. Maryland 21221 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donation 5 \$ Other (Specify) Entombment Gardens of Faith Cemetery 2/8/96 22. Nama and Addrass of Foolity
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222 21. Signature of Futheral Service Licensee One 23a. Pert1. Enter the inference or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each lina. Approximete Interval Between Onset and Deeth Physician RESPIRATORY FAILURE.

Due to (or es e consequence of): /Medical immediate Cause (Finel diseese or condition rasulting in deeth) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in deeth) Lest and ed by the attending physician datached for use as the buria Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown HAEMMOYTHAGIC CEREBROVASCULAR EVENT ð Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy NAL FAILURE completion of causa of death? 2 No certificata 1 ☐ Yes 2 ☐ No Be 25. Wes case raterred to medical 26. Place of Deeth (Check only one) Hospitel: 1 → patient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No After this 28c. Injury et Work? Medical Certification: 27. Mennar of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Neturel 2 Accident 5 Pending investigation 4-1996 death. 1 Yes ZZNo 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) end manner as steted.

2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pieca, and due to the cause(s) end menner steted. 29e. Certifier

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0020

Baltimore,

The law requires that the death certificate be executed or Attending Physician: ours after death eral Director: A filled in by the f To the Hospital c within 24 hours at To the Funeral D completely filled i

29c. License number

29d. Dete signed (Month, Dey, Year)

MTo-t. MD 30. Name end address of person who completed cause of death (item 23e) (Type, Print)

MOHAMMAD TAQIMO 6710 HOLABIRD ANEN BALT MD 2 1222

31. Dete filed (Month, Day, Year) State Registrar

29b. Signeture end title of certifier

32. Flegistrar's Signeture

2 mla far in

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 2. 23 PART I, II, PER DR State of Maryland / Department of Health and Mental Hygiene 95 03516

| | riln | g- | /32 2/22/90 t.t | | | Certificate of | Death | Re | g. No. | 0 03340 |) |
|---------------------|---|----------------|---|---|----------------------------------|--|--|--|------------------------------------|---|------|
| | Dhuala | | 1. Decedent's Nama (First, Middla, La | | | | | 2. Deta of Deeth Month | | 3. Time of Death | h |
| | Physic /Medi | | | Willia | m Georg | e Gorsch | | February | | 7:15 P | .M. |
| | Examlı | | 4a. Facility Nama (If not institution, gi | | | | 4b. City, Town, or L | | 4c. County o | f Death | |
| | | | 4100 Townsend | | | | Baltimo | | N/A | | |
| | Funeral Director | | 218 03 0054 | Sax 7. Ag 1⊠M 2□ F | a (In yrs. last b | Yrs. If Undar 1 Yaa Months Days | | 8. Data of Birth (Month, Day, March 15 | Year) 5,1921 | 9. Birthpiaca (Stata or Fora Country) Maryland | iign |
| | and w | | Usuai Rasidence of Decedant 10a. Stata 10b. County | | 10d. Inside City Lim | ite | | | | | |
| | Mary | ō | Maryland N/A | | Balt. | imore | | | | 1 2 Yas 2 □ N | |
| | 1 the | Director | 10a. Street and Number | | | 10f. Zip Coda | | 10 | g. Citizan of Wi | nat Country? | |
| | h with | a D | 4100 Townsend A | venue | | 212 | 25 | | U.S | • | |
| 020 | s 1 and 2 should be filed within 72 hours effer death with the Maryland Health end Mental Hyglene. Health end Mental Hyglene. The marked other than "natural", or ferms 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Maritai Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Armed Forcas? 1 ∑ Yas 2 ☐ If If Yas, Giva Yaer or Datas: | No | 13. Was Decedant of If Yas, specify Cul | | pecify Yas or No- Rican, atc.) | | - Amarican Indian, , Whita, atc. White | |
| Maryland 21215-0020 | "natural", | bet | 15. Decedant's E | ducation | | a. Decedant's Usual Occu | pation | 1 | 6b. Kind of Bus | | |
| 215 | within 7 ene. than "n | Completed | (Specify only highast gr Elementary/Secondary (0-12) | ada completed) Coilaga (1-4or : | 5+) | Decedant's Usual Occu (Giva kind of work done lifa. DO NOT usa ratin | during most of worked) | ring | | 11231.1124 | |
| 2 | Should be filed with end Mental Hygiene. Is marked other than sumatic event, the M | Con | 12th | Oonaga (1 401) | E | lectric Cons | struction | В | alto. G | as & Electri | .C |
| pu | tal and the second | Be | 17. Fathar's Nama (First, Middle, Last | | | | | a (First, Middla, Mi | |) | |
| yla | Men Men | 2 | | William G. | | | | ohanna Ma | | | |
| Mai | 12 sh h end h end r ls m traum | | 19a. informant's Name/Raiationship | (Type, Pnint) | | b. Meiling Addrass (Stree | | | | | |
| | ges 1 and t of Health if item 27 or other tr | | Edna Gorsch 20a. Mathod of Disposition | | | 100 Townsen of Disposition (Name of | d Avenue | | | cyland 21225 | |
| Baltimore, | 00- | | 1 ☐ Buriai 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 🛣 Other (Speci | W Entombme | cemat | ary, crematory or other plant Hill Cem | | | | ore, Maryland | 1 |
| Bal | permit. Pag Department Important: I any Injury o | | 21. Signature of Funeral Saprilea Lice | Soo | ue | 22. Nama and Addr | nie Highwa | ay Balti | more, M | Iome P.A. Id. 21225 | |
| | | | 23e. Part1. Enter tha diseasa, or com shock, or heart failura. List only | plications that causac ona causa on aach li | the death. Do | not antar tha moda of dy | ing, such as cardiac | or raspiratory arras | st, | Approximata interval Between | |
| | Physician /Medical Examiner | | immediate Causa (Final disassa or condition rasulting in death) | a. / | Carple | Myocan | Ind wy | Jodin | | M wufes | |
| | | je | | | HYPERT | consequentate of): FNST()N | V | | | YEARS | |
| | vacuted a and al-transi | Examiner | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. ————— | | consequance of): | | | _ | | |
| x 68760, | deeth certificets be axecuted e attending physician and ed for use es the burial-transit | Aedicai | causa. Enter undarying Cause (Disassa or injury that initiated evants resulting in death) Last | d | | | | | | | |
| Box | attendir for use | Physician/ | | | | | | | | I | |
| o. | | ysi | Part ii. Other significant conditions | ontributing to death b | ut not rasulting | in the underlying cause g | Ivan in Part I. | | | ribute to the cause of deat | |
| Δ. | 8 8 | by Pt | - Cur | MOS | 1 | al colo | | 1 U Yes | 8 2□ No | 3 Probably 4 Ø Unkno | own |
| Records, | requir been s should | Completed I | Non | gath |) NE | NINGIOMA | | 24a. Was an perform | autopsy ed? | 24b. Wara autopsy finding available prior to completion of causa of death? | S |
| Ä | 0 - 0 | EO | -040 | and 1 | | | | 1□ Yas | 2 No | 1 ☐ Yas 2 ☑ No | |
| Vital | ysiclan: The social social director, par | Bec | 25. Wes casa rafarred to medical axaminar? | 1 1 | | | 26. Placa of Daa | th (Check only ona |) | | |
| of V | 0 0 | 2 | 1 Yas 22 No | Hospital: y inpatia | | utpatient 3L DOA | | oma 5 Rasidar | ice 8 DOther | (Specify) | |
| | Ing After Une | ation: | 27. Manner of Deeth 1 Naturai 5 Panding 2 Accident invastigatio | 28a. Date of Inju (Month, Da) | ry Year) 28b. | Time of 28c. injury Wo | ury at ork?] Yas 2 □ No | 28d. Dascribe hov | v injury occurre | d | |
| Division | al or Attand s after death il Director: / | Certification: | 3 Sulcida 8 Could not be data rmined | | ury - At homa, f c. (Specify) | arm, street, factory, offica | | 28f. Location (Stre City or Town, | | r or Rural Routa Number, | |
| | To the Hospital or within 24 hours after To the Funeral Director Completely filled in E | edicai (| 29a. Certifier (Check only one) | nysician: To the best of niner: Of the basis of and mannar sta | axamination a | a, daath occurred at tha t nd/or invastigation, in my | ima, date end piace, opinion, daath occur | and dua to the cau red at tha tima, dat | use(s) and man ta and piace, ar | nar as stated. nd due to tha causa(s) | |
| | To the within To the comple | M | 29b. Signature and title of certifiar | () | | 29c Dican | se number |) 29 | d. Data signed | (Month, Day, Year) | |
| | OX! | | 30. Nama and addrass of parson who | completed sause of d | eath (itam 23a) | (Type, Print) | | | // | 10 | _ |
| | 10, | | DR SidNeu | GEhl= | et. | 1600 CRA | in Hww | 6-101 | BUR | wie, Md2100 | 61 |
| | Sta Registr | | 31. Dete tiled (Month, Day, Year) FEB1 3 1996 | 32. Registr | ar's Signeture | | | , , | | 1 | |

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| . NOW THE STATE OF THE COUNTY THE COUNTY THE COUNTY THE COUNTY THE COUNTY THE COUNTY OF THE COUNTY O | FUNERAL DIRECTOR: After this certificate has been signed by the attending physicism and companies filled in by the funeral directs, page 5 should be detached for use as the burial- | | WESTER OF TAXABLE AND AND AND AND AND AND AND AND AND AND |
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| , | NERA | I within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, crimination, or removal. | ALT: 04 |
| 2 | 5 | with | NAME OF |

| | 1. DECEDENT'S NAME (First, Middle, | e Joseph Gar | ul in | | | 1.2 | DATE OF DEATH | | 976 | TIME OF DEATH |
|--|--|--|--|--|--|--|--|---|---|--|
| | 4. SOCIAL SECURITY NUMBER | | AGE (illy yes, later birthur | ley) FUNDER I | YEAR IF UNDER | | DATE OF BIRTH | , 17 | | ACE (State or Foreig |
| | 212-36-7248 | 1 □X × 2 □ F 9 | | MONTHS. | DAYS HOURS | Marr C | eptember 23 | 100/ | Mary (| and |
| | Ss. FACILITY NAME (If not institution, | | /1 // // // // // // // // // // // // / | Bb. CITY, 1 | DWN OR LOCATIO | | | | | |
| R | Levindale | | | Baltimore Baltimore Baltimore | | | | | | |
| E | RESIDENCE OF DECEDER | | | | di ombi c | | | | 1471 | |
| DIRECTOR | | YTWUO | 10c. | CITY, TOWN OR | | | | | - 10 | Od. INSIDE CITY LIMITS? |
| 1000 | Maryland | N/A | | Balt | imore | | | | | X VES 2 - NO |
| RA | | 2022-000 | | | 10f. ZIF CODE | | | 10g. CIT | TIZEN OF WHAT COUNTRY? | |
| FUNERAL | 701 East Lake Av | PENUE 12. WAS DECEDENT BY | | | 21212 | - | | | USA | |
| BY FL | 1 Never Married 2 Merried | FORCES? 1 | 17 1 YES 2 X NO If yes, | | res, specify Cuban | DECEMBENT OF HISPANIC ORIGIN? (Specify Yes 1. specify Cuban, Mexican, Puerto Rican, etc.) YES XX NO Specify: | | filack, White, atc. | | - American Indian, White, etc. White |
| ETED | 15. DECEDENT | S EDUCATION | 16a. DECEDEN | T'S USUAL OCC | UPATION | | 18b. KIND OF BUS | INESS/INC | OUSTRY | 1010.50 |
| E | (Specify only highest Elementary/Secondary (0-12) | College (1-4 or 5+) | Milk. Do NO | or work done du 77 uter retired.) | ing most of working | - | | | S. (1977) | |
| COMPL | - 8 | · roundedersteint | Police | man | | | Bal | timon | e City | |
| 8 | 17. FATHER'S NAME (First, Mickelle, La | N. | | | 100000000000000000000000000000000000000 | | (First, Mickelle, Maiden | Surname) | - | |
| BE | | Joseph Martin Gavin Anna Teresa Trilhoff | | | | | | | | |
| 0 | THE INFORMANT'S NAME (Type-Print | 8 | | | | | N Mumber, City or Town | | | |
| - | P.G.Phebus 701 East Lake Avenue Baltimore, Maryland 21212 | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 1) Burtel 2 □ Cremation 3 □ | Removal from State | 206. PLACE AND DA | | lone | | | City or Town | | |
| | 4 Doppetion 5 Other (Specify) DULaney Valley Memorial Gardens 2/16 Lutherville, | | | | | | | | | |
| 21. SAGNATURE OF FUNERAL SERVICE VIOLENCE VIOLEN | | | | | | | | | | |
| | Nemmy | 1) 40 Key/X | mark | (8) | 6500 York | Road | Baltimore, | Maryl | and 212 | 212 |
| | 23. PART L Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cerdlec or respiratory errest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | |
| | Sequentisity ilst conditions, if say, leading to immediate Due to (or As a consequence of): | | | | | | | | | |
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| | resulting in death) LAST d. NGW uppor lobe preumons a | | | | | | | | | |
| E | | d. 1 . 7 W | | | | | | | | |
| 빙 | PART ii. Other algorificant con- | | | | | lean to m | - 1 | A 1 4 4 4 4 4 4 | | |
| 빙 | PART II. Other algnificant con | ditiona contributing to dee | th but not requiti | ng in the und | erlying ceuse gi | | 0.000.00 | | A | WAILABLE PRIOR TO |
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| OR ATTENDING PHYS | 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be defacthed for use as the burial-transft narmit page 1.2.3 security | be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|------------------------|--|---|--|
| TO THE HOSPITAL OR ATT | TO THE FUNERAL DIRECTO | be filed within 72 hours at | IMPORTANT: If item 2 |

| | | | | | | | | 0 | 36 | 03548 | |
|--------------------|---|---|-----------------------|-------------------------|--|--|---|-----------|---|---|--|
| | 1 - STATE REGISTRAR | STATE OF MARY | YLAND / D Cef | EPART RTIFI | MENT OF | HEALTH AND | MENTAL HYGIEN | E | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH | GREE | ENICO | TD: | CET | | 2. DATE OF DEATH | W | YEAR | 3. TIME OF DEATH | |
| | | | GE (In yrs. last b | | | I | | 1199 | | 2 AM " | |
| | | 40.00 | | | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) | | |
| | 9a. FACILITY NAME (If not institution, give stre | Λ // | | 1110. | OL OUTY TOWN | OR LOCATION OF D | Dec, 5, 19 | | | yland | |
| Œ | 1126 Hoods Mill R | | | | | | EATH | | NTY OF DI | | |
| DIRECTOR | RESIDENCE OF DECEDENT | Jau | | | Cool | esville | | | Howa | rd | |
| R | 10a. STATE 10b. COUNTY | | | 10c. CITY | TOWN OR LOCA | TION | | | | 10d, INSIDE CITY | |
| | Maryland Howa | rd | | Coc | kesvill | .e | | | | LIMITS? | |
| AL | 10s. STREET AND NUMBER | | | | 10 | f. ZIP CODE | | 10g. CIT | IZEN OF W | HAT COUNTRY? | |
| 띨 | 1126 Hoods Mill | | | | 21723 | | | U.S | . A . | | |
| BY FUNERAL | 1 Never Married 2 Married 3 Widowed 4 Divorced | R IN U.S. ARME ES 2X NO R DATES | ED | If yes, s | CENDENT OF HISPA ecity Cuban, Mexico 2 A NO Specif | NIC ORIGIN? (Specify Yea an, Puerto Rican, atc.) fy: | or No- | | - American Indian, white, etc. y: White | | |
| 8 | 15. DECEDENT'S EDUCA | TION | 16a. DECE | DENT'S L | JSUAL OCCUPATI | DN | 16b, KIND OF BUS | INESS/IND | DUSTRY | | |
| COMPLETED | (Specify only highest grade or Elementary/Secondary (0-12) | College (1-4 or 6+) | (Give | kind of we o NOT use | ork done during m retired.) | ost of working | | | | | |
| 를 | High school | | C1 | erk | | | Telep | hone | Co. | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden : | | | | |
| BE (| Adolf Brueckmann | Hilda | Childress | | | | | | | | |
| TO E | 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| F | Phillip H. Greenstreet 1126 Hoods Mill Road Cookesville, MD 21723 | | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 1 Burlel 2 D-Cremetion 3 Remove 4 Donation 6 Other (Specify) | darion decimation 2/0/30 nampstead, MD | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | Navy 7 | 11 Hai | | | | ral Home | | | | | |
| | 23. PART I. Enter the diseases, or col | mplications that carry | and the death | h Do no | P.O | Box 19 | 5 Sykesvil | e, M | D 21 | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | |
| | iMMEDIATE CAUSE (Fine) disesse or condition | 144 | -l- | 9' | Caral | indua | wlar Di | CECA | .0 | Onset and Death | |
| | resulting in death) a. | DUE TO (OR AL | S A CONSEQUE | ENCE OF | AVO | 1000036 | 20441 71 | 200 | | Tears | |
| TION | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | |
| ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | S A CONSEQUE | ENCE OF) | : | | | | | | |
| 뜅 | - d. | | | | | | | | | | |
| PHYSICIAN: MEDICAL | Stroke, Seiz | | but not resi | uiting In | the underlyin | g cause given in | Part i. 24a. WAS AN A PERFORI | MED? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| N. | DID TOBACCO USE CONTRI | BUTE TO CAUSE | OF DEATH | 1 YES | ON [| UNCERTAII | N IX | | | 1 TES 2 NO | |
| 8 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE C | OF DEATH | (Check only one) | | | | | | |
| <u>s</u> | | OSPITAL: | utpatient 3 🗆 | | OTHER: United Incoming Hori | a 6 Residence | 6 Other (Specify) | | | | |
| ВУ РН | 27. MANNER OF DEATH Netural 5 Pending 2 Accident Investigation | 2 | 66. TIME | | RK? | 26d. DESCRIBE HOW INJURY OCCURED | | | | | |
| <u>a</u> | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJUI building, atc. (Sp | RY — At home, pecify) | , farm, str | reet, factory, offic | | 261. LOCATION (Street and Number of Burel Route Number, City or Town, State) | | | | |
| COMPLET | | | | | | | to the cause(a) and mani- time, data and place, and | | | and manner as stated. | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | me. 1 | MD | MI | 2) | 29c. LICENSE NUM | | | | (Month, Day, Year) | |
| 일 | 30. HAME AND ADDRESS OF PERSON WHO | OMPLETED CAUSE OF I | DEATH (ITEM O | 7) /Tens 5 | Briedl | | | | _ | 11,110 | |

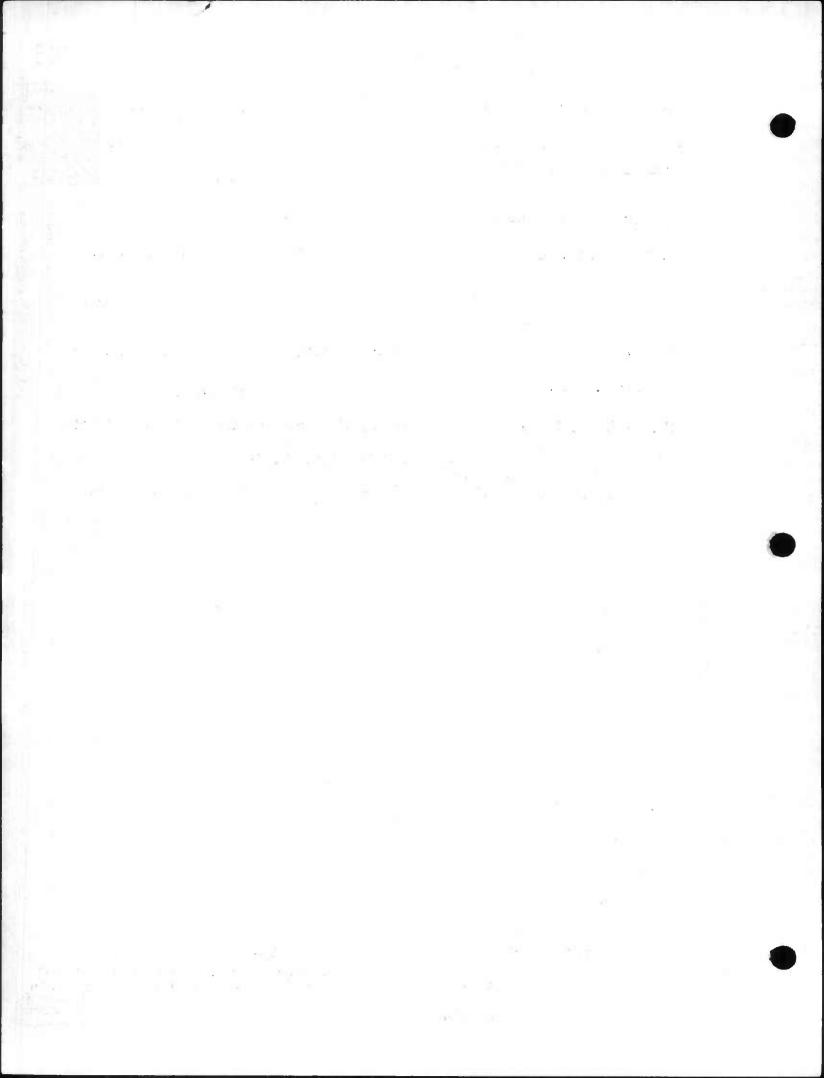
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| | | | | State of Ivia | | Certific | | | | Reg. No. | | |
|---------------------|---|--------------------------|--|---|--------------------------------|-------------------------------|---|---|--|---|-----------------------------|---|
| | Physici | an | 1. Decedant's Nama (First, Middla, Last) | | | | | | 2. Data of Dea Month | ith Day | Yaar | 3. Tima of Death |
| 4 | /Medi | | Mirton Jean | | gan | | | | Februa | 10/8,19 | 96 | 2:40 pm |
| | Examir | er | 4a. Facility Nama (If not Institution, giva si | treat and number) | | | | 4b. City, Town, or Lo | cation of Death | 4c. County | | |
| | | | Johns Hopkins Bayvi | | cal Cen | | | Baltimore | | | N/A | |
| | Funeral Director | | 217 00 2107 | M 2√ F 7. Age | (In yrs. last bin | Yrs. If Ur Moni | hdar 1 Yaar hs Days | If Undar 24 Hrs. Hours Min. | 8. Data of Birtl (Month, Day Aug. 2, | 7, Year) 1935 | 9. Birthpi Count Mary | aca (Stata or Foreign try) 1Land |
| | how | | Usual Rasidanca of Decedant 10a. Stata 10b. County | | 10c. City, Town | n or Location | - | 0 10 | | | 10 | Od. fnsida City Limits |
| | n the Marylen r 28a-f show Lncuffed at | Director | Maryland Balt 10e. Street and Number | timore | | 101 | 7in Code | Dundal | | 10-02 | | 1 □ Yas 2 ☑ No |
| | eth with | rai Dir | 3127 Dunglow Road | | | | Zip Code | 21222 | | 10g. Citizan of V United | | |
| 020 | be filed within 72 hours efter deeth with the Marylend of briginen. I hygiene. I hefural', or items 23e or 28e-f show event, the Madical Examiner must be notified at | by Funeral | 11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced | 2. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ② N If Yas, Giva Year or Datas: | | | ecedant of P specify Cub s 2⊠ No | dispanic Origin? (Sp an, Maxican, Puarto Specify: | ecify Yes or No- Rican, atc.) | 14. Rad Blac Specify | e - Amarica ck, Whita, a | atc. |
| Maryiand 21215-0020 | | Completed | 15. Decedant's Educi (Specify only highast grada Elamantary/Secondary (0-12) 12 Yearts | ation com <i>plated)</i> Collega (1-4or 5- | 16a. | | Isual Occup work dona Tuse retire | oation during most of work d) | ing | 16b. Kind of Bi | Serv | |
| and 2 | | Be | 17. Fathar's Nama (First, Middla, Last) Herbert W. Slater | | | 7 009-00 | | 18. Mother's Name | | Maidan Suman | | |
| anyie | d 2 should be filed th and Mentel Hyg 7 is marked othe traumatic event, | To | 19a. Informant's Name/Ralationship (Typ | e, Print) | 19b. | Meiling Add | rass (Street | Anna Ma and Number or Run | | | Stata, Zip | Code) |
| Z | elth a | | Mr. Harlan H. Hage | an | 3 | 127 Du | inglou | Road Du | ndalk, | Marylan | d 21 | 222 |
| Baltimore, | permit. Pages 1 and 2 Department of Heelth a Important: If item 27 is any injury or other tra | | 20a. Mathod of Disposition 1X☐ Burial 2 ☐ Cramation 3 ☐ Ra 4 ☐ Donation 5 ☐ Othar (Specify) | | 20b. Placa of camatar. | v. crematory | or other pla- | m. Pk.2/1 | | 20c. Location - | | wn, Stata Varyland |
| Baltin | | | 21. Signature of Funeral Service Cicenses | 1-4 | 7// | 22. Nami | and Addra | ss of Facility Functor H | ame ah | Dundalb | Tno | |
| _ | | | Charles of | 1/2 | 4 | 7922 | Wise | Ave. Dun | dalk, M | aryland | 212 | 22 |
| | Physician | | 23a. Part1. Enter the diseese, or complications, or heart teilure. List only one | ations thet caused causa on aach iiri | use death. Dor | ot enter tha r | noda of dyli | ng, such as cardiac o | or raspiratory an | rast, | | Approximata fntarval Between Onsat and Death |
| | /Medicai Examiner | | Immediate Cause (Final disaasa or condition rasulting in daath) a. | Myocar | dial In | nfarct | 100 | | | | | 5 days |
| | | ē | | | | | | | | | i | |
| | uted | Examiner | Segmentially list and distant | | CUIAT - | | | a | | | | 5 days |
| o | exec an an rial-tr | Ex | Sequantially list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disaasa or injury c. | | | | | | | | | |
| 68760, | ficete be execute physician and is the burial-trans | edicai | that initiated avants | | neumat Dua to (or as a c | | | - diseas | ie. | | - | |
| | | | resulting In deeth) Last | | **** | | | nt (this | e) | | | |
| . Box | death cert e attending od for use | icla | Part il. Other significant conditions contr | ibuting to death but | not resulting In | the underlyin | on cause ok | ren in Part I | 23h Did to | obacco use co | ntribute to | the cause of death? |
| 7. O | es thet the death cert igned by the attendin be detached for use | Phys | thyroid concer | | | ana ondanya | ig outse gr | arriir arti. | | 'ss 2□ No | | ebly 4 Unknown |
| or vital Records, | law requires as been sign 2 should be | Completed by Physician/M | chronic atnal f | | | | | | 24a. Was a perfor | an autopsy med? | ava | ra autopsy tindings llable prior to apletion of causa |
| Ě | certificate has rector, page 2: | Somp | | | | | | | 1 U Y | as 200 No | | laath? |
| <u>=</u> | artific octor, | Be | 25. Was casa ratarred to medical axaminar? | | | | | 28. Placa of Daati | Check only or | na) | | |
| | this co | 2 | 1 Yas 2 No Ho | spitai: 1 Sunpatlan | t 2 ER/Out | tpatient 3 | DOA Oth | ar: 4□ Nursing Ho | ma 5 Rasid | anca 8 🗆 Oth | ar (Specify |) |
| 5 | Attending Physician: v.derth. ector: After this certific by the funeral director. | ation: | 27. Mannar ot Death 1 ☑Natural 5 ☐ Panding 2 ☐ Accident invastigation | 28a. Data ot Injury (Month, Day | Year) 28b. T | ima ot njury M | 28c. fnjur Wor 1 🗆 | y at k? Yas 2 □ No | 28d. Dascribe h | ow Injury occur | red | |
| Division | or Att | Certification: | 3 ☐ Sulcida 6 ☐ Could not be datermined | 28a. Place of inju- building, atc. | ry - At homa, fai (Specify) | m, streat, tac | tory, office | | 28f. Location (S City or Tow | treat and Numb n, Stata) | er or Rural | Routa Number, |
| | To the floeping or Attending Physician: The law within 24 hours and dead. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edicai (| 29a. Cartifiar 1 Certifying Physic (Check only one) | clan; To the best of ir: On the basis of e end manner stat | examination and | daath occuri Vor Invastige | ed at tha tir | na, data and place, a pinion, deeth occurr | and dua to tha c ed at tha tima, d | ausa(s) and ma lete and place, | nnar as sto and dua to | ated. tha cause(s) |
| 1 | Vithir Nomp | | 29b. Signatura and titla of certifiar | 0 | | | 29c. Licans | a number | 2 | 29d. Data signe | d (Month, L | Day, Year) |
| | 1 | | > Keta a | talcor | l | | Di | 47782 | | 2-9 | -96 | |
| | 12 | | 30. Name and eddress of person who com | plated causa of de | | Type, Print) | | s Hopkins Eastern | | | | |
| | Sta | te | 31. Date tiled (Month, Day, Year) FEB 1. 3 1996 | 32. Registrar | | | 7740 | LUSTOM | /110, 15 | J. I. | -, 1 | 2 21227 |



Item1 2-13-96 FilmG732 W.H.Per F/H

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03550

| | | | | State of Maryland / 1 | Certificate of | | rental myglen Reg. N | | 0000 |
|---------------------|--|----------------|---|---|--|---|---|----------------------|--|
| | 15. | | 1. Decedent's Nama (First, Middla, Las | • | | | 2. Data of Death | | 3. Tima of Death |
| | Physic /Medi | | DARRYL | Andre | HARR | ISON F | EBRUARY | 5,1996 | 4:24P.M |
| | Exami | | 4a. Facility Nama (If not institution, giva | street and number) | | 4b. City, Town, or Lo | cation of Death | ic. County of Death | |
| | Funeral Director | | 13 BR- 720. | CIRCLE 7. Aga (In yrs. last bi | rthday) If Undar 1 Yaar Yrs. Months Days | F.I.I.T COT If Undar 24 Hrs. Hours Min. | T CITY H 8. Data of Birth (Month, Day, Yea) | 9. Birth | COUNTY placa (Stata or Foreign ntry) |
| | land | | Usual Rasidance of Dacedant 10a. Stata 10b. County | / 10c. City, Tow | n or Location | | | | 10d. Insida City Limits |
| | 72 hours efter deeth with the Meryland natural', or flems 23a or 28a f show sited Examinet must be notified at | Director | 10e. Stréet and Number | BA BA | 101. Zip Coda | | 100.6 | Citizan of What Cou | Jay 2□No |
| | 3a or | | 1827 N. KEGS | Ester Street | | 1213 | | USA | |
| | 999 | Funeral | 11. Marital Status | 12. Was Dacedant Evar In U,S. Armed Forcas? | 13. Was Decedant of I | Hispanic Origin? (Spe | cify Yas or No- | 14. Race - Amar | |
| 020 | ours efter al', or he Examine | by | 1 Nevar Married 2 Marriad 3 Widowed 4 Divorced | 1 Tas 2 Ho If Yas, Giva Yaar or Datas: | 1 □ Yas 2 □ No | | nican, atc.) | Specify: Bk | c/c |
| 5-0 | "natural", | eted | 15. Decedant's Edi (Spacify only highast grad | ucetion 16a | Decedent's Usual Occup (Giva kind of work dona life. DO NOT usa retige | pation during most of worki | 16b. | Kind of Businass/In | |
| Maryland 21215-0020 | y within | Completed | Elamantary/Secondary (0-12) | Collega (1-4or 5+) | | 1 pen | Ct | 5 FAUI | KREO, For |
| pu | be filed tal Hygi d other | Be | 17. Fathar's Nama (First, Middla, Last) | | | 18/ | (First, Middla, Maide | en Sumama) | |
| 7 | should be and Mental I marked or | 2 | ARYMOND - | TY2 ZIEN | | Cloria | | | |
| Ma | C/ 0 = 0 | | 19a. Informant's Name/Ralationship (T | (M) / 196 | o. Meiling Address (Street | 1) 4. | HOUTE Number, City | or Town, Stata, Zi | p Code) |
| | Health Health Iom 27 | A | 20a. Mathod of Disposition | 20b. Place C | f Disposition (Nama of | EG&STER | Data 20c. | Location - City or T | 7 |
| MO | 0 6 4 7 | | 1. Burial 2 □ Cramation 3 □ I 4 □ Donation 5 □ Othar (Specify, | Hamovai from Stata | ry, cramatory or other pla | 10/102 | -10-96 | moulit | x hel |
| Baltimore, | ~ 5 5 5 · | | 21. Signature of Funaral Sarvice Licent | 10 | 22. Nama and Addre | ass of Facility 5 | 240 RE1 | STENST | an LUMB |
| m | Depar Impor any Ir | | Langer of | | Oli Adam | - la con | 11/ h | Honar 1 | 012111 |
| r | | | 23a. Part I That the disease, or companion in heart feilure. List only of | licetions that caused the death. Do | not antar the moda of dyl | ng, such as cerdiac of | | 111/10014 | Approximate Interval Batween |
| | Physician /Medicat Examiner | er | Immediata Causa (Final diseasa or condition rasulting in death) | Gultiple | consequence of): | ev | | | Onset and Death |
| _ | ficate be executed g physician end es the buriel-transit | Examiner | Sequantially list conditions, if any, leading to immediate | b Dua to (or as a | | | | | |
| 68760, | be e. Sician burie | alE | Sequantially list conditions, if any, leading to immediata ceuse. Entar Undarlying Causa (Diseasa or Injury thet initiated evants | C | | | | | |
| 687 | | edical | rasulting in death) Last | Dua to (or as a | consaquance of): | | | | |
| Box | | M/ul | | d | | | | | |
| | death e etter | sicia | Part II. Other significant conditions co | ntributing to daath but not rasulting i | n tha undarlying causa gi | van in Part I. | 23b. Did tobacc | co use contribute | to the cause of death? |
| s, P.O | es thet the death cer igned by the ettendin be deteched for use | by Physician/W | | | | | 1 🗆 Yee | 2 No 3 Pro | obably 40 Unknown |
| Vital Records | requir | Completed t | | | | | 24a. Was an au performad? | a | /ara autopsy findings vailabla prior to empletion of ceuse |
| Re | has ge 2 | duic | | | | | | | daath? |
| ā | | 0 | 25. Was casa rafarrad to medical | | | 26. Placa of Death | | 2□ No 1 | Yes 2 No |
| <u>=</u> | Physician: this certific rel director, | To B | axaminar? | Hospital: 1 ☐ Inpatiant 2 ☐ ER/O | utpatient 3 DOA Oth | han | ma 5 Rasidance | 6 ☑Othar (Spec | (v) STREET |
| n of | ding Phys h. After this funerel di | | 27. Mennar of Death 1. □ Neturei 5 □ Panding | | Tima of 28c. Inju | | 28d. Dascribe how in | | abject |
| Division | Attending ar death. ector: Afte by the fune | Certification: | Accident invastigation | 215/96 14 | | Yas 2□No | struck by | garbel | Aruch |
| Ž | or Attendent of the Collector: | THE STATE OF | 3 Suicida 6 Could not be 4 Homicida datermined | 28e. Place of Injury - At homa, fa building, atc. (Specify) | arm, straat, factory, office | 1 | 28f. Location (Street City or Town, Sta | and Number or Rui | ral Routa Number, |
| | ours e | | One Continue of Continue | vode | Way | | Circle, He | ward Com | ty Many las |
| | To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral | edical | 29a. Certifiar (Check only one) 1☐ Certifying Phy (Check only one) | elcian: To the best of my knowledge inar: On the basis of examination an and mannar stated. | dor investigation, in my | ma, data and place, a opinion, daath occurre | and dua to tha ceusal ed at tha tima, data a | nd piace, and dua | to tha causa(s) |
| | o the | Me | 29b. Signatura and titia of certifiar | and mannar states. | 29c. Licans | sa number | 29d. C | Data signed (Month | , Day, Year) |
| | r s r ö | | The | U K | 4 | C M 12 | mer | עם גוום | 1006 |
| | 5 | | 30. Nama and addrass of person who co | ompleted ceusa of daato (Itam 23a) | | .C.M.E. | PEE | BRUARY 6 | , 1990 |

111 Penn Street, Baltimore, Maryland 21201

13.44

Items4b, 10c, 17 2-13-96 FilmG732 W.H.Per F/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 95 Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 7, February 1996 11:30 PM Catherine M. Harrison /Medical 4b. City, Town, or Location of Deeth Phoenix Baltimore 4e. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Scotts Moore Court Baltimore 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Nov. 18, 1909 Marykand 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foreign **Funeral** 1 M 2 F Days Yrs. Director Nov. 216-07-5504 86 Usual Rasidanca of Dacadant the Maryland 10a. Stata 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Heelih and Mental Hygiene.
Important: If then 27 is marked other than "natural", or itema 23a or 23a-f show any injury or other traumatic event, fre Medical Examiner meal to nothing any injury or other traumatic event, fre Medical Examiner meal to nothing a 10d. Insida City Limits Phoenix 1 Yas 2 No Directo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21131 2 Scotts Moore Court U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ñ No if Yas, Give Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Stetus 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White p 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usuai Occupation 16b. Kind of Business/Industry (Giva kind of work dona duning most of working life. DO NOT usa retired) Elemantary/Secondary (0-12) Coilega (1-4or 5+) 7th grade Homemaker Own Home 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Timmins Merrill S. Timmons Anna M. Bierau 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2 Scotts Moore Court. Phoenix. Maryland 21131 Kenneth J. Miller Sr. (Son) 20b. Piaca of Disposition (Nama of cematary, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Crematory 2/10/96 Baltimore, Maryland 21. Signatura of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part1 There the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest,

Approximent Approximete Interval Batween Onset and Death **Physician** /Medical immediata Cause (Finai diseasa or condition rasuiting in death) **Examiner** Examiner the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaase or Injury that initieled evants resulting in daath) Last Dua to (or as a consequence of): Records, P.O. Box 68760. ettending physician Physician/Medical Dua to (or as a consequence of): USB 85 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Wara sutopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 certificate has 1□ Yes 20 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospitator, Attending Physician: within 34 hours atter death.

To the Fungral Director: After this cartifica completely filled in by the funeral director, Be 25. Was case rafarred to medical 26. Placa of Death (Check only ona) axaminer? Other: 4 Nursing Home 5 Pesidence 8 Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28d. Dascribe how injury occurred Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suiclda 6 Could not be datarmined Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Piece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and dua to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination end/or invastigetion, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. Medical 29e. Cartifiar (Check only one) 29b. Signeture and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of

State Registrar

Andrew of the second gradient date dan de date

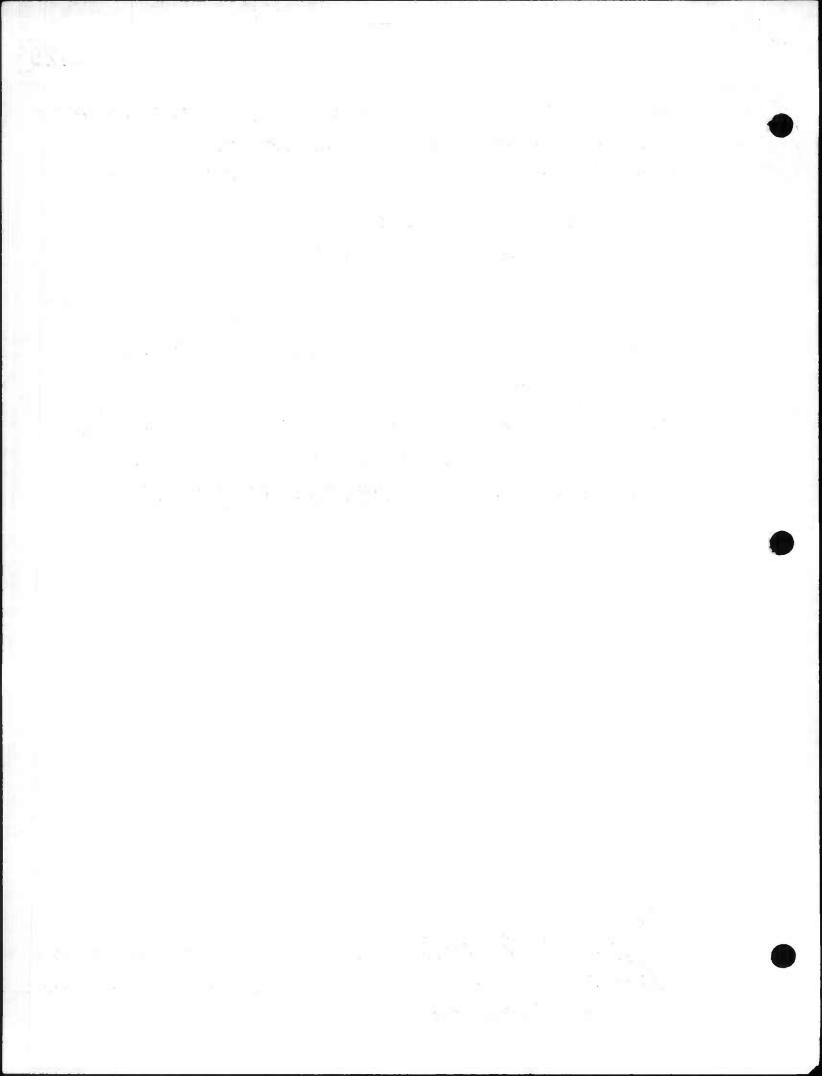
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State of Maryland / Department of Health and Mental Hygiene

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| | | 1. Decedant's Nama (First, Middle, Last) | | | 2. D | ata of Death | 3. Tima of Death | | |
| | sician edical | | | HOPKINS | | onth Day | Year 1996 0205AM | | |
| | minei | A - F - III - Alama - Manakinaki - Alamaki - Alamakinakina | eet and number) | | b. City, Town, or Location | | ty of Death | | |
| | 4 | JOHNS HOPKINS HO | | | ALTIMORE C | ITY | | | |
| Funer Direct | | 5. Social Security Number 6. Sax 219 80 9863 # N | 7. Age (In yrs. lest) | birthday) If Under 1 Yeer Months Days | Hours Min. 8. Do | eta of Birth fonth, Day, Year) 10/61 | Birthplace (State or Foreign Country) MD. | | |
| /and | | 10a. Stata 10b. County | 10c. City, To | own or Location | | | 10d. Inside City Limits | | |
| Man | ţ | MD. BALTO. CI | ITY BAL | TIMORE | | | 1∰ Yas 2□ No | | |
| th the | Ser le | 10e. Street and Numbar | | 10f. Zlp Code | | | f What Country? | | |
| ath wi | 100 | 4504 SPRINGDALE | AVE. | 21207 | | USA | 4 | | |
| re, Maryland 21215-0020 I and 2 should be filed within 72 hours after death with the Manyland Hatith and Mental Hygiene. The strain of Mental Hygiene. The strain of the strain and the strain stra | hy Funeral Director | 3 ☐ Widowed 4 ☐ Divorced | Wes Decedent Ever in U,S. Armed Forcas? 1 _ Yas _ 2# No If Yas, Give Year or Datas: | 13. Was Dacedant of Hi If Yas, specify Cuba 1 ☐ Yas 2 ☐ No | spanic Origin? (Specify Y n, Maxican, Puarto Ricen Specify: | | ace - American Indian, eck, Whita, atc. | | |
| 5-0 72 ho | 1 | 15. Dacedant's Educat | ion 16 | Sa. Decedant's Usual Occupe | etion | 16b. Kind of | Businass/Industry | | |
| 121 | Completed | (Specify only highest grade of Elemantery/Secondary (0-12) | Collaga (1-4or 5+) | (Give kind of work done d life. DO NOT use retired | | BALTO | O, CITY WATER DEPT. | | |
| d 212 filed with Hygiene. ther the | ٥ | 12 | 2 | MAINTENANCE | | | | | |
| Maryland d 2 should be file th end Mental Hy 7 is marked othe traumatic event, | 8 | 17. Fathar's Name (First, Middle, Last) JAMES GIN | / A D D | | 18. Mother's Name (Firs | | ame) | | |
| aryla should nd Mer marke | F | 19e. Informant's Name/Ralationship (Type, | | | HOPKINS I Route Number, City or Town, State, Zip Code) | | | | |
| , Ma and 2 shalth er alth er 127 is er trau | | ANGELA HOPKINS | | 4504 SPRINGDA | | | 1207 | | |
| altimore, N mit. Pages 1 and partment of Health portant; if New 27 y Injury or other tr | | 20a. Mathod of Disposition | 20b. Place | of Disposition (Name of tery, crematory or other place | | | - City or Town, State | | |
| Pages hant of int: If its | | 1 | IOVALITOTTI SCHOOL | | 0/96 | ARBUTUS | S, MD. | | |
| Baltimore, N permit. Pages 1 and Department of Health Important if fem 27 any injury or other to | 8008 | 21. Signature of Funeral Service Licensee | Let. 1 | 22. Nama and Addras | STHERS FUNER | AL HOME P. | ١. | | |
| - | | 23a. Part1. Enter the disease, of complices shock, in part tailura. List only ona | tions that caused the death. D | o not enter tha moda of dying | g, such as cardiac or rasp | olratory arrast, | Approximete Interval Between | | |
| Physicia /Medic Examin | al | Immediata Cause (Finel disaasa or condition rasulting in daath) e | Grusha | of Would | of Cf | 111.4 | Onset and Death | | |
| outed and ansit | Examiner | Sequentially list conditions | | e consequence of): a consequence of): | | | | | |
| 68760, tificate be executed g physician and es the buriel-transit | edical Ex | If any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | |
| | 190 | | , | . , | | | | | |
| . 0 0 2 | Physiclan/N | Pert II. Other significant conditions contrib | outing to death but not resulting | In the underlying cause give | en in Part I. | 23b. Did tobacco uee o | contribute to the cause of death? | | |
| P.C at the d by the | Phy | 1 | | | | 1 Yes 2 No | 3 Probably 4 Unknown | | |
| Records, P.O. Box ne law requires that the death cer a has been signed by the attendir tge 2 should be detached for use | Completed by | | | | | 4a. Wes an autopsy performad? | 24b. Wara autopsy findings available prior to complation of causa | | |
| 0 8 8 W | amo | | | | | M. solv | of death? | | |
| | | 25. Wes casa rafarred to medical | | | 26. Plece of Deeth (Che | 10 Yes 2 No | 1 Yes 2 No | | |
| raicia s cent direct | o Be | axaminar? | pital: 1 ☐ Inpatient 2 SER/ | Outpatient 3 DOA Othe | ar. | Rasidanca 6 □0 | thar (Specify) | | |
| | Ë | | | o. Time of 28c. Injury Injury Work | | escribe how injury occ | | | |
| Sion o tending Ph leath. tor: After th | atio | 1 Neturel 5 Panding 2 Accidant invastigation | 2-5-96 0 | | Yas 2□No SU | bied 8 | Test | | |
| Division of Vital a or Attending Physician: The there death. The there death. The there is certificated in by the funeral director, pages in by the funeral director, pages. | Certification: | 3 Sulcida 6 Could not be detarmined | 28a. Place of Injury - At home, building, etc. (Specify) | farm, streat, factory, office | 28f. L | ocation (Street and Numity or Town, State) | ber or Rural Route Number, | | |
| Division of the Hospital or Attending Physician 24; Dours after death. To the Further all pirector: After the completely fillight in by the funeral | edical | 2 Medical Examinar | an: To the best of my knowled: On the basis of examination and end manner stated. | and/or investigetion, in my op | pinion, daath occurred at | ha tima, data and place | e, and dua to tha causa(s) | | |
| TANT | Σ | 29b. Signature and title of certifier | 0 111 | 29c. Licanse | number | 29d. Date sign | ned (Month, Day, Year) | | |
| .(| | 1 wint | stell | 0.C. | M.E. | FEBRU | ARY 05, 1996 | | |
| 10 | | 30. Nume and address of person who comp | $v = 4\Lambda()$ | | most Dis | | | | |
| | State | 31. Data filed (Month, Day, Year) | 32. Registrar's Signatura | 111 Penn St | reet, Bali | imore, M | aryland 21201 | | |
| Regi | | FFB 1 3 1996 | Makerharlet | ž. | | | | | |

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Pages 1, 2, 3 should

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funeral director, page 5 should be detached for use as the burial-transit

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after d | FLIMERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the | within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ITANT: If Nem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical ex |
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96 03553 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last)

Matheway 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1240 Hun VAN 996 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 12/12/1948 IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 213-46-1796 1 M 2 - F MARYLAND 47 YRS. 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR LEVINDALE GERIATRIC CENTER BALTIMORE BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3304 WEST GARRISON AVENUE 21215 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, atc. 1 Never Married 2 Narried Specify: BLACK BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
('Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 **JANITOR** JANITORIAL COMPANY once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 76 MATTHEW HUNT SR. RITA BE CHAMBER notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 RITA CHAMBER 4012 PINKNEY ROAD BALTIMORE, MARYLAND 21215 must be 20e. METHOD OF DISPOSITION

1 X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION --- City or Town, State "WESTERN" STAR CEMETERY 2/1/1996 CATONSVILLE, MARYLAND ☐ Donation 5 ☐ Other (Specify) _ examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ESTEP BROTHERS FUNERAL HOME PA. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217 23. PART i. Enter the diseases, or complications that clused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. medicai **IMMEDIATE CAUSE (Finel** Onset and Daath the th disease or condition Myocardial Infarction resulting in death) injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) Hypertension CERTIFICATION Sequantially list conditions. DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY Respiratory shows any Failure 1 - YES 2 100 OF DEATH? 14 erebro UKSCH Accidents 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN **PHYSICIAN**: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem EXAMINER? HOSPITAL OTHER: Inpetient 2 - ER/Outpatient 3 - DOA g Home 5 - Residence 6 - Other (Specify) marked, or MANNER OF SEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Natural Accident 5 Pending Investigation М 1 YES 2 NO В 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) .00 Suicide 6 Could not be 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 [] Homicide 28 29e. CERTIFIER ation and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated. PORTANT 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 27,1996 9

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Mudler Re

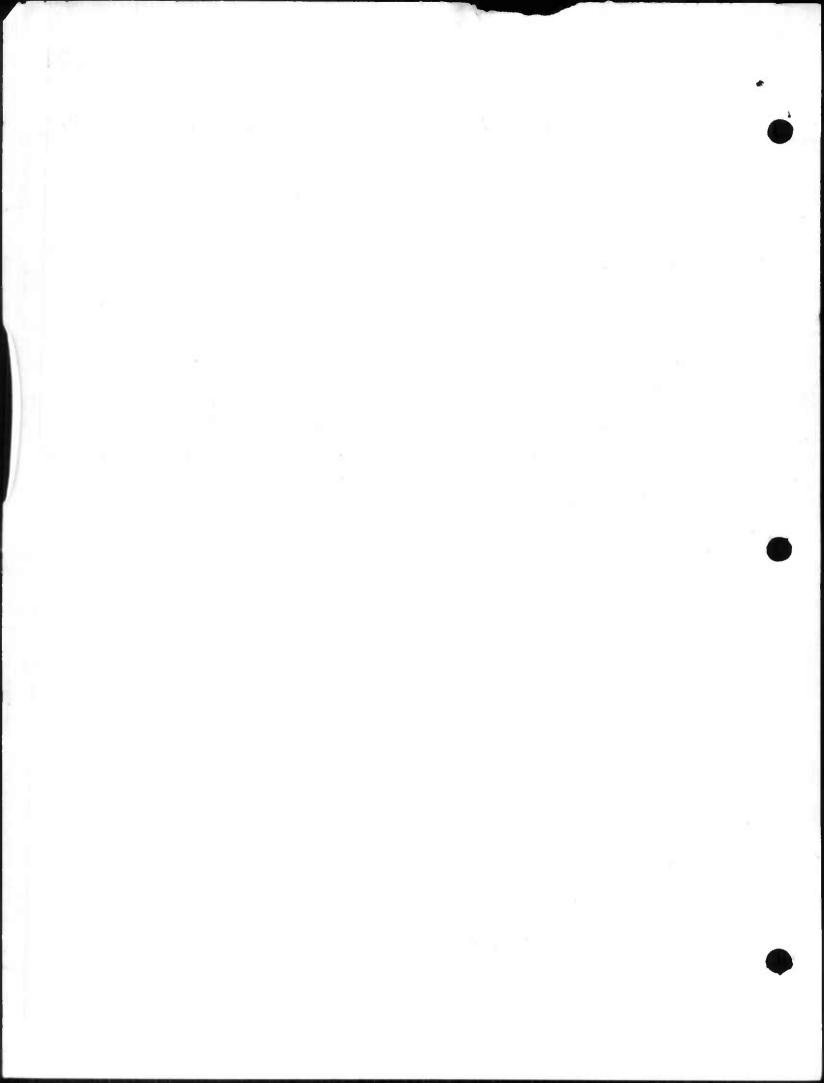
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DOBEA S 31. DATE FILED (Month, Day

3 1996

DHMH-16 Rev 1/89

| • | | FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|---|----------------------------|--|--|---|--|---------------------------|--|--|--|-------------------------------|--|
| | | t. DECEDENT'S NAME (First, Middle, Last) | l H:// | Mod | | | 2. DATE OF DE. | NTH / DAY YEAR / 2 | | | |
| RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020 requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. or health and Mental Hygiene prior to burial, cremation, or removal. shows any injury, or other traumatic event, the medical examiner must be notified at once. | ETED BY FUNERAL DIRECTOR | 4. SOCIAL SECURITY NUMBER 228-28-5241 | 1√7M 2 □ F | yrs. last birthday) 68 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | 7. DATE OF BIR (Month, Day.) |) 1927 | BIRTHPLACE (State or Foreign Country) VIRGINIA | | |
| | | 90. FACILITY NAME (If not institution, give street end number) 90. CITY, TOWN OR LOCATION OF DEATH 8c. COUNTY OF DEATH 8c. COUNTY OF DEATH 8c. COUNTY OF DEATH N/A | | | | | | | | | |
| | | MARYLAND N/A | | 10c, CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| | | 2213 Baker Stre | <u>-</u> | 10f. ZIP CODE 21217 | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| | | 11. MARITAL STATUS t Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEOENT EVER IN U. FORCES? 1 YES : IF YES, GIVE WAR OR DATE | | 2 X NO If yes, specify Cuban, Mexicen, Pue | | | , Puerto Rican, e | | | | |
| | | 15. OECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | JCATION e completed) College (1-4 or 5+) | | USUAL OCCUPATION work done during more retired.) | | 16b. KIND | OF BUSINESS/INDUS | | | |
| | COMPL | 12th 17. FATHER'S NAME (First, Middle, Last) | IAME (First, Middle, Last) | | | Presser 18. MOTHER'S NAME | | | Cleaners (First, Middle, Melden Surname) | | |
| | BE | Fdward Hill 190. INFORMANT'S NAME (Type/Print) | 19b. MAILING | Blonnie Edwards G ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) | | | | ode) | | | |
| | 5 | Webester Hill | 5109 D | Durand Street, Oxon Hill, Maryland 20748 | | | | | | | |
| | | 1X] Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. 7ion Cemetery 12/12 BALTIMORF MARYLAND | | | | | | | | | |
| | | 21. SIGNATURE OF AUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE | | | | | | | | | |
| | AL CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) B. A. C. T. D. I. N. A. F. C. II. R. E. I. | | | | | | | | |
| | | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): METASICATIC TROUBLES CANCER LO days LO days LO days LO days DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | | | | | | | | | PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY FINDINGS PERFORMED? AMALABLE PRIOR TO | | |
| | | MEDIC | Nme | | | | | | YES 2 NO | COMPLETION OF CAUSE OF DEATH? | |
| | AL law has b Dept. | IAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | |
| DIVISION OF VITA OR ATTENDING PHYSICIAN: The OIRECTOR: After this certificate it hours after death with the State it item 28 is marked, or item | BE COMPLETED BY PHYSICIAN: | EXAMINER? 1 YES 2 AD HOSPITAL: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 27. MANNER OF DEATH 280. DATE OF INJURY 28b. TIME OF 28c. INJURY AT | | | | | | ☐ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED | | | |
| | | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | (Month, Day, Year) INJURY WORK? M 1 YES 2 NO | | | and Department from Indon't decorate | | | | |
| | | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY - building, etc. (Specif | e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Flural Route Number, City or Town, State) | | | | |
| ₹ ₹ ₹ = | | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner as stated. | | | | | | | | | |
| TO THE FUNER THE FUNER OF filed within | | 29b. SYMATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | |
| - P 2 E | 70 | Maria Miliam W D15698 F658, 1996 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARCOS GALICÍA MO Bon Socour Way Till Baltinum Mel 21223 | | | | | | | | | |
| San Paris . | | MARCOS GA 31. DATE FILED (Month, Day, Year) | LICIA MO | BM | - Sicou | v \$1647. | Til B | a Himore. | Md 21223 | | |
| | | FFR 1 2 100c | 1. At 1 | 1 | / | • | | | | | |



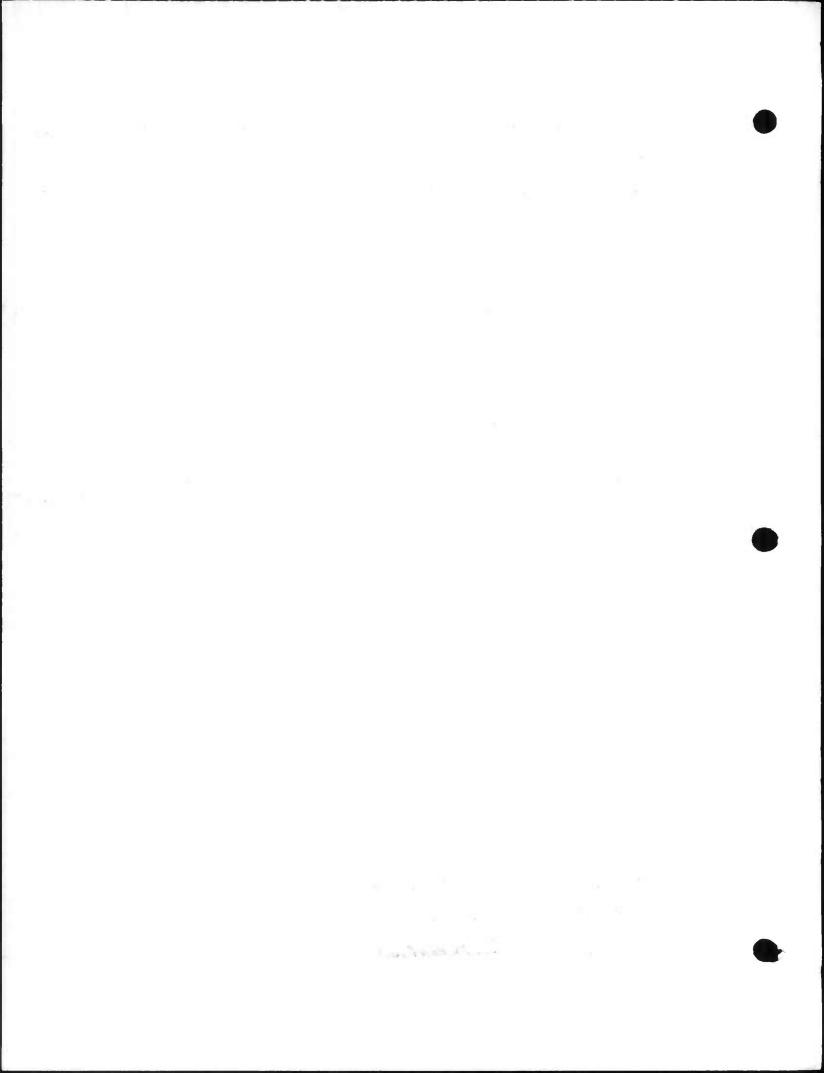
FOR STATE REGISTRAR

1 -

| BALLIMORE, MARYLAND 21215-0020 | YSICIAN: The law requires that the death certificate be executed within rivours after death. Page 6 may be retained by the hospital or attending physician. | a sertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal. | the medical examiner must be notified at once. |
|--------------------------------|---|---|--|
| THE HECORDS, P.O. BOX 68760, | TO THE MAZINAL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within | TO THE RUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the fill the control of the fill the fill the state Dept. of Health and Mental Agiene prior to burial, cremation, or removal, | IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, | | | | | | | | | 2. DATE OF DEA | | | 3. TIME OF DEATH |
|---------------|--|-----------------|------------------------------|----------------------------|-----------------------|----------------------|------------|---------------|----------|-----------------------------------|----------------|---------------|--|
| | Bernard Jo | <u>hn Hei</u> | 1ker | | | | | | | February | 9, 199 | 6 YEAR | 12:55 A. M |
| | 4. SOCIAL SECURITY NUMBI | | 5. SEX | 6. AGE (In yr | s. last birthday) | | R 1 YEAR | | 24 HRS. | 7. DATE OF BIRT (Month, Day, Y | | S. BIRT | HPLACE (State or Foreign |
| | 213-09-0710 | | 1 ₹ M 2 □ F | 81 | YRS. | MONTHS | DAYS | HOURS | MIN. | FEB. 21 | 1914 | Mar | yland |
| ~ | 9a. FACILITY NAME (If not ins | | | | | | | OR LOCATI | ON OF D | | 9c. O | OUNTY OF E | |
| 0 | Meridian Nu | | Center, H | erring | HKWY. | Hi. | 11en | dale | | | В | altim | ore County |
| E C | 10e. STATE | 10b. COUNTY | | <u> </u> | 10c. CITY | , TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY |
| DIRECTOR | Maryland | Balti | more Cou | inty | | son | | | | | | | LIMITS? |
| AL | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP COD | E | | 10g. (| CITIZEN OF | WHAT COUNTRY? |
| E | 517 Brook Ro | ad | | | | | | 2128 | 6 | | | U. | S.A. |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDEN FORCES? 1 | LEVER IN U.S | ARMED | 13. | | | | NIC ORIGIN? (Spec | | - 14. RAC | E — American Indian, |
| BY | 1 Never Married 2 X I 3 Widowed 4 Divor | | World Wa | AR OR DATES | | | | 2 NO | | m, Puarto Rican, a y: | IG.) | Spec | White |
| | 15. DECE | DENT'S EDUC | ATION | | . DECEDENT'S (| ISUAL O | VCCI IBATI | N. | | day Mana | OF BUSINESS/ | 1 | wuite |
| | (Specify only Elementary/Secondary (0- | highest grade o | College (1-4 or 5 + | | (Give kind of wi | ork done | during mo | st of working | ng | 100, KIND (| F BUSINESS/ | INDUSTRY | |
| 릴 | 11 | .2, | College (1-4 of 5 4 | | Steam F | itte | er | | | Heati | no Pli | mhin | g,Fower |
| COMPLETED | 17. FATHER'S NAME (First, Mic | idle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, Middle, N | | | 6,10WCL |
| BE (| Victor | | | Hei | lker | | | E1: | izab | eth | | F | rommer |
| ဥ | 19e. INFORMANT'S NAME (Ty) | | | | | | | | | Route Number, City | | Zip Code) | |
| - | Mrs. H. Vir | | <u>Heilker</u> | | 517 Br | ook | Roa | d, To | owso | n, Maryl | and, | 21286 | |
| | 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 X Cremation | 3 Remov | val trom State | 20b. PLA | CEAND DATEO | FDISPOS per place | SITION (Na | me of | | 1 | oc. LOCATION | | |
| | 4 Donation 5 Other (| | NSEE | Gree | n Moun | | | OTY | | 2/12 B | altimo | ore, 1 | Maryland |
| | - 11 | 25 | 06 | _ | | 22. | Mit | chel. | 1-Wi | edefeld | Home, | Inc. | |
| _ | John | | ung/ | | | | 650 | O You | ck R | oad, Bal | timore | e. Mai | ryland 21212 |
| | 28. PART /. Enter the dia ehock, or he | ert feilure. Li | int only one csu | t caused the se on eech | deeth. Do no line. | ot enter | the mo | de of dy | Ing, suc | h aa cerdiac or | reepiratory | arreat, | Approximate interval Between |
| | iMMEDIATE CAUSE (Fine disease or condition | ы | 10 | - | , | | | | | | | | Onset and Death |
| | reaulting in deeth) | → a. | Nege | LULL | ASEQUENCE OF | ers | eas | ea | , | | | | 15 yes. |
| _ | | | | (0.1 7.0 7. 00) | ISEADENCE OF | ,- | | | | | | | , |
| <u> </u> | Sequentieity ilst condition if any, leading to immed | ons, | DUE TO | (OR AS A CO | SEQUENCE OF) | k: | | | | | | | - |
| <u>8</u> | cause. Enter UNDERLYIN CAUSE (Disease or injur | IG | | | | | | | | | | | |
| | thet initiated eventa resulting in death) LAST | | DUE TO | (OR AS A CO | ISEQUENCE OF) | 1: | | | | | | | |
| CERTIFICATION | | d. | | - | | | | | | | | | |
| | PART ii. Other eignifican | conditione | contributing to | deeth but n | ot resulting in | the u | nderlying | cauee q | given in | Pert i. 24a. W | AS AN AUTOPS | Y 24b | . WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | | | | | | ES 2 NO | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | _ | 21 | | 1 TES 2 NO |
| Ž | DID TOBACCO US | | BUTE TO CA | | | | | UNC | ERTAI | V 🗆 | | | |
| ᅙ | 25. WAS CASE REFERRED TO EXAMINER? | | HOSPITAL: | | LACE OF DEATH | (Check | | _ | | | | | |
| PHYSICIAN: | 1 YES 2 NO | | 1 Inputient 2 I | | 26b. TIME | | | | eldence | 8 Other (Specifi | | | |
| | 1 Netural 5 P | | (Month, De | | INJU | RY M | | RK7 | ¬ NO | 26d. DEŞCRIBE I | IOW INJURY (| OCCURED | |
| ĕ I | 2 Sutette | ould not be | 28e. PLACE OF | F INJURY — A | t home, term, st | reet, tac | | | | 281. LOCATION (S | treet and Num | her or Rumi I | Poute Number |
| | | etermined | building, | atc. (Specify) | | | | | | City or Town, | State) | | |
| | 29a. CERTIFIER (Check only | FYING PHYSICI | AN: To the best of | my knowledge | , death occurred | at the t | time, data | and place | and due | to the cause(s) so | d manner ee | deted | |
| COMPLET | | | | | | | | | | | | | s) and manner as stated, |
| | 29b. SIGNATURE AND TITLE | | 1 | | | | | | ENSE NUN | | | | (Month, Dev. Year) |
| | Druce | -6 | Lasey | lue | gus | 0 | | D2 | 417 | _1 | • | | 9, 1996 |
| 2 | 30. NAME AND ADDRESS OF | | | | | | | | 11- | | | | |
| | | | | | | | | | | | | | |
| H | Bruce Roser | nberg, | M.D. 51 | 5 Fair | mount 1 | Aver | nue, | Tows | son, | Marylan | <u>d S</u> uit | e 300 | 21286 |
| | Bruce Roser 31. DATE FILED (Month, Day, W | sar) | 32. REGISTRA | R'S SIGNATUR | E | | nue, | Tows | son, | Marylan | d Suit | e 300 | 21286 |
| | 31. DATE FILED (MONIN, Day, 16 | sar) | M.D. 51 | R'S SIGNATUR | E | | nue, | Tows | son, | Marylan | d Suit | e 300 | 21286 |



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

| 6876 | |
|-----------|--|
| BOX | |
| P.O. | |
| RECORDS, | |
| F VITAL B | |
| ONOISIONO | |
| | |

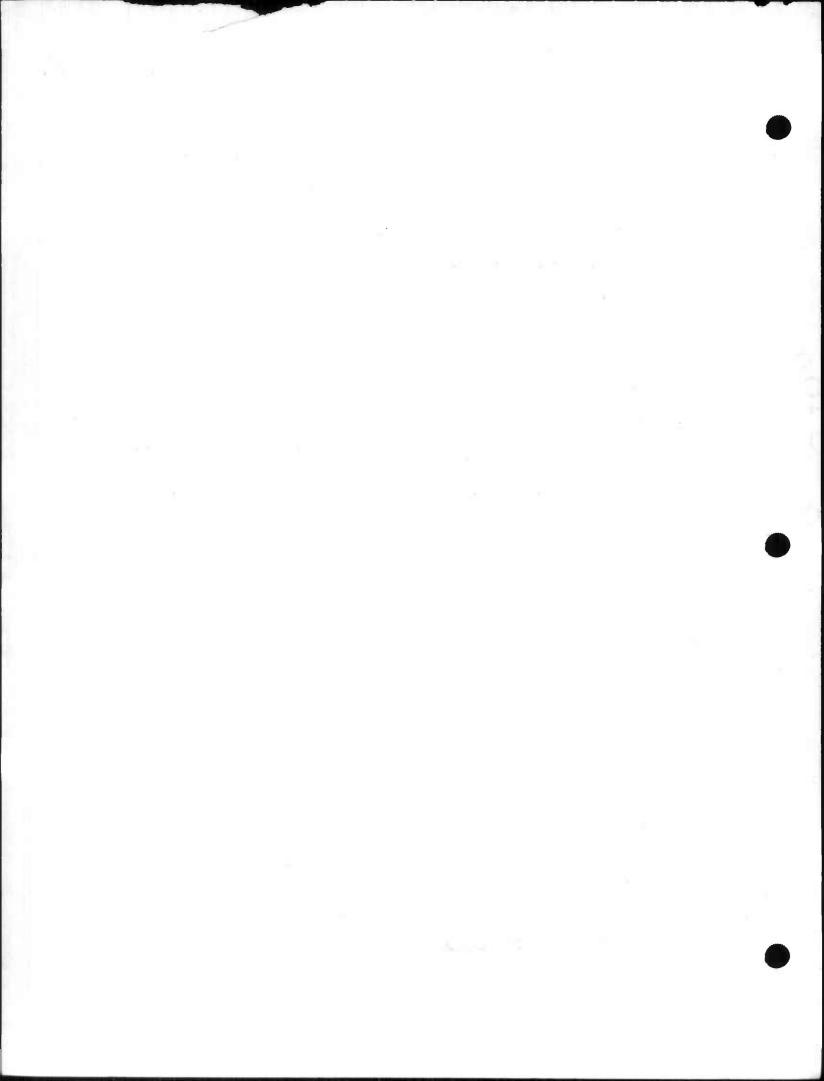
| į | 1. DECEDENT'S NAME (First | , Middle, Last) | CATHER | TME | | TI. | ILBEI | DΠ | | | MONT | OF DEATH | W 100 | 96 | | ME OF DEA | |
|----------|---|---|---|--------------|--------------|--------------|--------------|------------|--------------------------|-----------------|-------------|---------------------------------|------------------|----------------------------|----------|-------------------------|---------|
| | JULIA 4. SOCIAL SECURITY NUM | 250 | | | | | | | | | Feb | | 19: | | | :30 | Рм |
| į | 218-36-1014 | BER | 5. SEX t | | (In yrs. les | YRS. | MONTHS | DAYS | HOURS | 24 HRS. MIN. | (Mon | t. 6, | 1938 | 6. BIRTH Countr | Y) | (State or Fi | Toreign |
| . | 9a. FACILITY NAME (If not in | nstitution, give s | street and number) | | | | 9b. CITY | , TOWN | OR LOCATION | ON OF DE | ATH | | 9c. COU | NTY OF D | EATH | | |
| הטוסשהוט | 1131 Green | Acre R | d | | | | | To | wson | | | | Ва | altir | nore | e | |
| | 10a. STATE | 10b. COUNT | | | | 10c. CIT | Y, TOWN (| OR LOCA | TION | | | | | | 10d. II | NSIDE CIT | Y |
| 5 | Md. | Bal | timore | | | | | To | wson | | | | | | | JMITS? YES 2 2 | NO |
| CINEDAL | 10s. STREET AND NUMBER | | | | | | | 10 | f. ZIP CODI | E | | | 10g. CIT | IZEN OF V | VHAT C | OUNTRY? | |
| | 1131 Green | Acre R | d. | | | | | | 21: | 286 | | | | U.S | .A. | | |
| 139 | tt. MARITAL STATUS 1 Never Married 2 🔀 | | 12. WAS DECEDI FORCES? IF YES, GIVE | 1 YES | 2 2 | | - 1 | If yes, sp | | n, Mexica | n, Puerto | N? (Specify Yes Ricen, etc.) | or No- | 14. RACE Black Speci | k, White | nericen Indi a, atc. | len, |
| | 3 Widowed 4 Div | orced | | | JAI LO | | | | 2 2 3 110 | Specin | <i>,</i> . | | | apec | | hite | |
| | t5. DEC (Specify on | CEDENT'S EDU ly highest grade | JCATION completed) | | /G | CEDENT'S | work done | during m | ON ost of working | 10 | 16 | b. KIND OF BUS | BINESS/INI | DUSTRY | | | |
| J | Elementary/Secondary (| 0-12) | College (1-4 or | 5+) | life. | Do NOT u | se retired.) | | | | ! | 0 | *** | | | | |
| 1 | 12 | Para San San San San San San San San San Sa | | | Hom | e Ma | ker | | | - | | Own Ho | | | | | |
| ı | tr. FATHER'S NAME (First, A | MICIONE, LEST) | Alexand | 302 | C | 1liv | 2.0 | | 18. MOT | | ME (First, | Middle, Maiden | Surname) | Nasl | h | | |
| i | Joseph 19a, INFORMANT'S NAME (| Type/Print) | Arexand | ier | | | | C /Ctmat | 1 | | Cloude Mus | nber, City or Tow | - Ctata 7 | | | | |
| | Mr. Wayne E | | ert | | | | | | | | | on, Md. | | | | | |
| | 20a. METHOD OF DISPOSIT | TION | | 20 | b. PLACE | AND DATE | OF DISPOS | SITION /N | ame of | | DA | TE 20c. LO | CATION — | _ | wn, Ste | eta | |
| | t X Burial 2 Cremati 4 Donation 5 Dithe | | noval trom State | Ç. | metery, cre | ey V | alle | у Ме | em. G | dns. | 2/12 | /96 T | imon | ium, | Md | | |
| | 21. SIGNATURE OF FUHER | IL SERVICE DE | CENSES | | | _ | 22. | NAME A | ND ADDRE | SS OF FA | CILITY | 7 ** | | | | | |
| ı | (this | 10 | UH | - | | | | | | | | eral Ho | | | 1 | | |
| 1 | 23. PART I. Enter the o | liseasas, or | complications t | hat cause | ed the de | ath. Do | | | | | | OWSON, | | | | Approxim | nsta |
| | shock, or h | neart fellure. | Liet only one c | ause on | aach lina | 1. | | | | | | | | | | Interval E Onset an | Between |
| | disease or condition | nai. | C | Ar 1 | Pul | M. OY | (a) | , | | | | | | | | | |
| ł | resulting in desth) | | DUE 1 | O (OR AS | Pul | DUENCE O | F): | | | | | | | | - 1 | x yr | 2 |
| ı | Constant that are dis | | · E | ms | A CONSE | en | ra | | | | | | | | 1 | 10 U | ~5 |
| I | Sequentially list condi- if any, leading to imme | ediata | DUE 1 | O (OR AS | A CONSE | DUENCE O | F): | 1 | | | | | | | | 2 yr 10 yr 30 u | |
| ı | CAUSE (Disesse or inj | | c. 51 | MOK | A CONSE | C | iga | ret | tes | | | | | | | 30 u | 125 |
| 1 | that initiated avents resulting in death) LAS | ST | DOL | EA 110) OI | A COMSE | JOENCE O | 1.4 | | | | | | | | i | | 9 |
| 4 | (<u> </u> | - | d, | | | | | | | | | | | | - | | |
| | PART II. Other algorific | ant condition | ns contributing | to death | but not i | esulting | In the u | ndariyir | ng causa | given in | Part I. | 24a. WAS AN PERFOR | AUTOPSY | 24b | | AUTOPSY F | |
| | | | | | | | | | | | | t 🗆 YES 2 | NO | | OF DE | PLETION OF EATH? | CAUSE |
| | | | | | | | | 1 | | | - | | | | 1 🗆 ' | YES 2 | NO |
| | DID TOBACCO U | | RIBUTE TO C | AUSE | | | | | | ERTAI | N \square | | | | | | |
| | 25. WAS CASE REFERRED EXAMINER? | TO MEDICAL | HOSPITAL: | | | CE OF DEA | OTHE | R: | | A | | | | | | | |
| | 1 YES 2 NO | | 1 Inpetient 2 | _ | _ | DOA 286. TIN | | | me 5 NR | eldence | | | N. H. HERV. O.C. | CHDED | | | |
| 1 | | Pending | | Day, Year) | | IN. | JURY | W | JURY AT ORK? YES 2 | NO | 200. DE | SCRIBE HOW I | NJUHT OC | CURED | | | |
| | 2 Accident 3 Suicide | Investigation | 28e. PLACE | OF INJUR | RY — At ho | me, farm, | street, fac | | | | 281, LO | CATION (Street | and Numbe | r or Rural i | Route N | lumber. | |
| | 4 Homicide | Could not be determined | bulldir | ng, stc. (Sp | ecify) | | | | | | City | or Town, State) | | | | | |
| ı | 29a. CERTIFIER | TIFYING PHYS | SICIAN: To the best | of my kno | wlados de | eth occur | rad at the | time det | e and aleas | and due | to the o | wasta) and ma | | and . | | | |
| | and ' | - / | ER: On the basis o | | | | | | | | | | | | a) end r | manner ea | stated. |
| | 295 SIGNATURE AND TITL | 1/ | | | | | | | | ENSE NU | | | | | | h, Day, Year, | |
| | (Na /IK | Tool | Pin- | Pers | onel | Ph | 18/ci | N | | 107 | - | | > | 2/1 | 2/ | 96 | , |
| | 30. NAME AND ADDRESS O | F PERSON W | HO COMPLETED C | | | | - | -11 | | , 0 / | | | - | - 1 | | - 0 | |
| | Harry M. Wa | len, M | 1.D. 400 | 0 01 | d Cou | rt R | d. P | ike | svill | e, M | Id. | | | | | | |
| | 31. DATE FILED (Month, Day | | 32 REGIST | | | | | | | | | | | | _ | | |
| | FFR 1 3 19 | 14h | ale d'auch | ar la | Alall | | | | | | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



0 ... 05

| | 1 - STATE REGISTRAR | SIAIE UF MI | ARYLAND / DI CER | | | | DEAT | | | YGIEN EG. NO. | E | | |
|---------------|--|--------------------------------|---|----------|---------------------------|-------------|---------------|-----------|------------------------|------------------|-------------|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 02.1 | | | | DEAT | • | 2. DATE OF D | EATN | | | 3. TIME OF DEATN |
| | | GRACE HOL | SOPPLE | | | | | T | MONTH EBRUAR | Y | | 996 | 3:10 amm |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX (| S. AGE (In yrs. lest bir | thday) | IF UNDER | | IF UNDER | | 7. DATE OF B | RTN | | 6. BIRTH | PLACE (State or Foreign |
| | 196-22-7538 | 1 🗆 M 2 🏋 F | 66 | YAS. | MONTHS | DAYS | HOURS | BATH. | Jan.1 | 6, 1 | 930 | Penn | sylvania |
| | 90. FACILITY NAME (If not institution, give s | treet and number) | | | 9b. CITY | , TOWN | R LOCATIO | N OF DE | ATH | | 9c. COU | NTY OF DE | |
| 8 | THE JOHNS HOPKIN | NS HOSPITA | \L | | BAI | TIM | ORE C | ITY | | | | N/ | A |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | v | | A- OIT | Y, TOWN (| DD 1 000 | 101 | | | | | | |
| Ë | | ltimore | 1" | | | | Rive | | | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | rcriiore | | | MIUC | - | ZIP CODE | | | | 10- 017 | | 1 YES 2 ANO |
| FUNERAL | 514 Bowleys Qu | uarters | Road | | | 10 | 2122 | | | | | .S.A | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. ARMED | D | 13. | WAS DEC | ENDENT O | F NISPAN | IIC ORIGIN? (Sp | ecify Yes | or No- | 14. RACE | - American Indian, |
| BY F | 1 Never Married 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE WA | YES 22 NO | | | If yes, sp | 2 XNO | n, Mexica | n, Puerto Ricen | , etc.) | | Black, Specif | , White, etc. |
| 8 | 15. DECEDENT'S EDU | | 16e. DECED | DENT'S | USUAL O | CCUPATI | ON | _ | 16b. KINI | OF BUS | SINESS/INC | DUSTRY | WILLO |
| Ш | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | life Do | NOT u | work done se retired.) | during mo | st of working | 9 | | | | | |
| 릴 | 12 | | Rece | pt | ioni | ist | | | Rec | rea | atio | n Ce | nter |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | ER'S NA | ME (First, Middle | , Maiden | Surneme) | | |
| BE (| Alfred Weis S | c | | | | | G. | lady | ys Bru | ımba | ugh | | |
| 0 | 19e. INFORMANT'S NAME (Type/Print) | | | | | | | | Route Number, C | | | | 21220 |
| | Patricia Rous | 1 | 7 | | | _ | | rte | | | | | . 21220 |
| | 1 Donetion 5 Other (Specify) | oval from State | 20b. PLACE AND cemetery, cremete Greenm | ory or o | ther place | FAM | ator | 17 2 | /1 A / 1 | 206. LO | | City or Ton | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | Greenin | iou. | | | | | Funer | | | | |
| | An B | 9: | \wedge | | | | | | Funer tern <i>I</i> | | | | |
| | 23. PAHT Enter the diseeses, or | omplications that | csused the deeth | n. Do i | | | | | | | | | Approximats |
| | ahock, or heert fellure. IMMEDIATE CAUSE (Final | List only one caus | e Dn each line. | | | | | | | | | | Interval Between Onset and Death |
| | | Genni | Failure | | | | | | | | | | 4 days |
| | resulting in death) | a. Senal DUE TO (| OR AS A CONSEQUE | NCE O | F): | | | | | | | | 1643 |
| Z | | D. Liver | Failure OR AS A CONSEQUE | | | | | | | | | | 2 ways |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | | | NCE O | F): | | | | | | | | |
| 5 | CAUSE (Disease or injury | a Acute L | evkema | | | | | | | | | | le 12 units |
| 造 | that initiated events | DUE TO (| OR AS A CONSEQUE | NCE O | F): | | | | | | | | |
| 览 | | d | | - | | | | | | | | | |
| | PART II. Other algnificant condition | na contributing to d | leeth but not resu | uiting | in the u | nderiyin | g ceuse g | liven in | Part I. 24a | | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| MEC | | | | | | | | | _ ' | | | | OF DEATH? 1 YES 2 NO |
| | DID TOBACCO USE CONT | RIBUTE TO CAL | JSE OF DEATH | l Y | ES 🗆 | NO E | UNC | ERTAI | N 🗆 | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE C | OF DEA | | | | | | | | | |
| SIC | 1 TYES 2 NO | HOSPITAL: | ER/Outpatient 3 🗆 | DOA | 4 Nu | | a 5 Re | eldence | 6 Other (Sp. | ecity) | | | |
| E | 27. MANNER OF DEATH | 26e. DATE OF II (Month, Day | | 6b. TIN | IE OF JURY | | URY AT | | 28d. DESCRIE | E NOW I | NJURY OC | CURED | |
| ВУ | 1 Netural 5 Pending 2 Accident Investigation | | | | М | 1 🗆 | | ND | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF building, e | INJURY — At home, tc. (Specify) | , ferm, | straet, fed | tory, offic | • | | 26f. LOCATION | N (Street o | end Numbe | r or Aurel A | loute Number, |
| COMPLETE | | | | | | | | | | | | | |
| 립 | 29e. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of n | ny knowledge, death | occum | red at the | time, det | and place, | end due | to the cause(e) | end me | nner ea sta | rted. | |
| S | one) 2 MEDICAL EXAMIN | ER: Dri the basis of axe | imination end/or inve | atigati | on, in my | opinion, | leath occur | ed at the | time, data and | placa, ar | nd due to t | he ceuse(e) |) and menner es stated. |
| BEC | 29b. SIGNATURE AND TITLE OF CERTIFIE | R | | | | | 29c. LICE | NSE NUI | MBER | | 29d. DAT | TE SIGNED | (Month, Day, Year) |
| 10 B | Kelly Ala. Intern | | | | | | 14 | 487 | | | >E4 | orver- | 10, 1994 |
| - | 30. NAME AND ADDRESS OF PERSON WI | O COMPLETED CAUSE | E OF DEATH (ITEM 2 | 7) (Type | e, Print) | | | | | | | | |
| | Kelly Gobo, Tower | 110, JHH, | 601 N. W | Ol.fe | 1t. | J. | 14, B | a in | ין שופין | U | 2120 | 5 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | 'S SIGNATURE | | | | | | | | | | |
| | FEB131996 | all dudes | Mardall | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Iniury, or other traumatic event, the medical examiner must be netified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYLAND / DE | PARTMENT OF HEAL TIFICATE OF DE | | NTAL HYGIENE | | |
|---------------|---|--|--|-------------------|---|-----------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Dorothy Lee Ja | | | DATE OF DEATH MONTH DAY | YEAR | 3. TIME OF DEATH |
| | -DOROTHY | -JACOBS- | | | 02 09 | | 11:35 Pm |
| | 4. SOCIAL SECURITY NUMBER 2/3-/4-9850 | 5. SEX 6. AGE (In yrs. last birt | thday) IF UNDER 1 YEAR IF U | | DATE OF BIRTH (Month, Day, Year) | 19 Surri | HPLACE (State or Foreign Y) G/N/A |
| | SE FACILITY NAME (If not institution, give str | | 9b. CITY, TOWN OR LO | CATION OF DEAT | H 777 | 9c. COUNTY OF D | - |
| DIRECTOR | Maryland General | Hospital | Baltimore | City | | Baltimo | re City |
| EC | 10s, STATE 10b, COUNTY | ./ | CE CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland L | 1/4 | BALTIMOR | | | | 1 VES 2 NO |
| FUNERAL | 1623 DLUID | Hill AUSNUE | 101. ZIP (| 21218 | • | 10g. CITIZEN OF V | WHAT COUNTRY? |
| 2 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WAS DECENDE | NT OF HISPANIC | ORIGIN? (Specify Year | or No- 14. RACI | E — American Indian, k, Whita, ejc. |
| BY F | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES | 1 Tyes, specify (| | Puarto Rican, atc.) | and the second second | five P |
| ED 8 | 16. DECEDENT'S EDUC | ATION IN DECEM | ENT'S HEHAL OCCUPATION | | Last vinio of Buot | NEGO (NICHOTON | Dack |
| ETE | (Specify only highest grade of | completed) (Give k | ENT'S USUAL OCCUPATION ind of work done during most of w NOT use retired.) | vorking | 186. KIND OF BUSI | | sily Hane |
| 7 | Elementary/Secondary (0-12) Grade | College (1-4 or 5+) UUVS | E Assistan | + | Commi | | f / MC |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | 1. 2. | 18. [| MOTHER'S NAME | (First, Middle, Meiden S | 'umame) | |
| i w | EDWAYD J | OHKSON | E | MMA | Konta | 900 | |
| TO B | 199-INFORMANT'S NAME (Type/Print) | 19b. M. | AILING ADDRESS (Street and Nu | mber or Rural Rou | te Number, City or Town, | State, Zip Code) | 1 |
| - | CHOLIA LITTLE | 180 | S Montfor | D HUE | BAHAM | 10 E. 16 | (211/3 |
| | 20a. METHOD OF DISPOSITION 1 Burlat 2 Cremation 3 Remo | oval from Stata 20b. PLACE AND | DATE OF DISPOSITION (Name of pry or other place) | 1/2 | 12-96 20c LOC | ATION — City or To | own, Stata |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | ENSEE ANATYLON | 22. NAME AND AD | 1 | LIK | 1181 // | aryprus |
| | the the | v | duadas | (/- | - 11 B | 16 | bed 313 15 |
| | 23. PARTA. Enter the/diseasea, or co | omplications that caused the death | Do not enter the mode of | The such a | St. N. 100 | PHONE I | Approximate |
| | | List only one cause on each line. | | , | | , | Interval Between Onset and Death |
| | disease or condition resulting in death) | Cardio pu | Imonary | arres | <u> </u> | | |
| | 1 | Intracrani | | 1 | | | |
| o | Sequentially list conditions, | DUE TO (OR AS A CONSEQUE | | 7 | | | -i |
| CAT | if any, leading to immediate cause. Enter UNDERLYING | | | | | | |
| Ĕ | CAUSE (Diseese or Injury that initiated events | DUE TO (OR AS A CONSEQUE | NCE OF): | | | | |
| CERTIFICATION | reaulting in deeth) LAST | J | | | | | |
| LC | PART ii. Other significent conditions | contributing to deeth but not resu | ilting in the underlying ceu | use given in Pa | rt i. 24a, WAS AN A | WTOPSY 24t | . WERE AUTOPSY FINDINGS |
| _ 5 | | - | | | PERFORM | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | | 77.71 | OF DEATH? 1 YES 2 NO |
| | DID TOBACCO USE CONTR | RIBUTE TO CAUSE OF DEATH | YES NO U | INCERTAIN | | | 1,00 |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE 0 HOSPITAL: | F DEATH (Check only one) OTHER: | | | | |
| YSI | 1 TES TONO | 1X Inputiant 2 ER/Outputlant 3 - | DOA 4 Nursing Home 5 | ☐ Rasidence 6 | Other (Specify) | | |
| H | 27. MANNER OF DEATH TY Netural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 8b. TIME OF 18c. INJURY WORK? | | 8d. DESCRIBE HOW IN | JURY OCCURED | |
| B | 2 Accident Investigation | AND DIAGON OF MINISTRA | M 1 YES | | | | |
| ED . | 3 Suictda 6 Could not be 4 Homicide detarmined | 26a. PLACE OF INJURY — At home, building, atc. (Specify) | farm, atreat, fectory, offica | 2 | 61. LOCATION (Street as City or Town, State) | nd Number or Rural | Route Number, |
| COMPLET | 29a. CERTIFIER CERTIFYING PHYSIC | CIAN: To the best of my knowledge, dash | occurred at the time, date and a | place, and due to | the cause(a) and many | ner as stated. | |
| M | | R: On the basis of examination and/or inve | | | | | a) and menner se stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | - 0 | | LICENSE NUMBE | | 29d. DATE SIGNED | O (Month, Day, Year) |
| O BE | | Shotsh (VE | | 89258 | | ▶ Februa | ary 5,1996 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH (ITEM 27 | 7) (Type, Print) | 77 . | 9 | | |
| | Suresh Verghe | se, M.D. c/o Mary | land General | Hospita | I.T | | |
| | FEB 1 3 1996 | 12-REATTAINS SIGNATURE | 1 | | | | |
| | FEB 1 9 1999 | / | | | | | |

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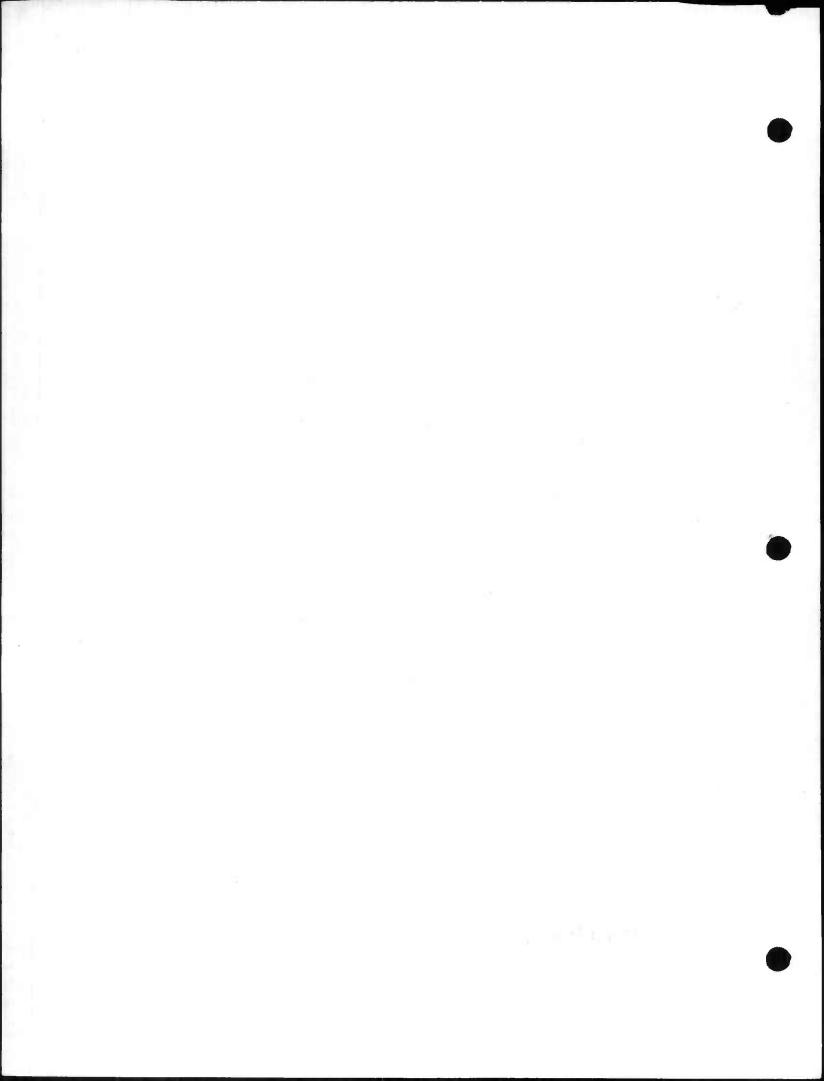
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| | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hou | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled is be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or |
| | $\stackrel{\sim}{=}$ | 广泛 |
| | 0 | 0 0 |
| | \sim | P 2 |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO. 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Walter Louis Jackson WALTER 2 10:45 6. AGE (in yrs. lest birthday) 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH IF UNDER I YEAR 8. BIRTHPLACE (State or Foreign DAYS 1 1 M 2 | F 215-01-7618 Mar 9e. FACILITY NAME (If not institution, give street and nut 9b. CITY, TOWN OR LOCATION OF CEATH 9c. COUNTY OF DEATH P SECOUKS ospital DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY FES 2 NO 1/AND SALFIMORE FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3045 AUENUE 2/2/6 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerio Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried Specify: Black 1 TES 2 NO Specify BY 3 Widowed 4 Divorced ETED 15. OECEOENT'S EOUCATION 16a. OECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest ve kind of work done Do NOT usa retired.) Elementary/Secondary (0-12) College (1-4 or 5+) rybock MARYLON COMPL HAMIC 4EAS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, how 185 JACKEM DA notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS /St 2 14001216 K500 Solfi MU18 200. METHOD OF DISPOSITION pe 20b. PLACE AND OATE OF DISPOSITION (Name of must Burlel 2 Cremation 3 Ramoval from State Narylows Donation 8 - Other (Specify) KENKOM W BUTUS examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE, 22. NAME AND AOORESS OF FACILITY REISTE 23. PART I. Enter the disease, or complications that caused the death. Do not enter speck, or heart failure. List only one cause on each line. HAMIS medical Interval Between IMMEDIATE CAUSE (Final Onset and Death the Ruga disease or condition Bila traumatic event, reaulting in death) OUE TO (OR AS A CONSEQUENCE OF) alou CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury ac or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events Cardior resulting in deeth) LAST come vicular Injury. PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any nence COMPLETION OF CAUSE 1 YES 2 100 Shows delmi 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL tem EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 0 28e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Matural 1 YES 2 NO BY investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 ls 8 Could not be COMPLETED 4 Homicide The I 29e. CERTIFIER (Check only Indicate and place) and due to the cause(e) and manner se stated. Ξ 2 MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as started. MPORTANT: 29b. SIGNATURE AND JITLE OF DETIFIER 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) B 1 CoRita 3303 w und 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CRU SECOURS KOSITA 1304 32. WEGISTAN S SIGNATURE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 96 03560

| 112 | | | | | Certificate of | | ionai riy | Reg. No | 03560 |
|-------------------|--|-------------------|--|-----------------------|--|---|---|---------------------------------------|---|
| | Physic /Medi | | Decedent's Neme (First, Middle, Last) Clayton J. Jaco Sr. | | | | 2. Dete of De Month | Dey | Year 3. Time of Deeth 12:40P |
| | Exami | | 4a. Facility Neme (If not institution, give street and number) | | | 4b. City, Town, or L | | | |
| | | | Ridgeway Manor Nursing Ho | me | | Catonsv | | | imore |
| | Funeral Director | | 5. Sociel Security Number 209-09-5021 Usuel Residence of Decedent | | thday) If Under 1 Yeer Months Deys | Hours Min. | 8. Dete of Bird (Month, De Aprill | th y, Year) 4,1914 | 9. Birthplace (State or Foreign Country) West Virgini |
| | Maryland H show | tor | | | or Location thorpe | | | | 10d. Inside City Limits 1 ☐ Yes 2 No |
| | ath with the Marylan 23a or 28a-f show | al Director | 10e. Street and Number 5630 Carville Avenue | | 10f. Zip Code 2 1 2 | 227 | | 10g. Citizen of W | That Country? States |
| 020 | or itama | by Funeral | 11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in Armed Forces? 1 Yes, Give Yes, Give Yeer or Detes: | U,S. | 13. Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No | | ecify Yes or No Rican, etc.) | | - American Indian, k, White, etc. - White |
| 21215-0020 | within ene. than " | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) | 16a. | Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Welder | pation during most of work d) | ing | 16b. Kind of Bu | ehem Steel |
| | be filed tel Hygi d other avent, u | Be | 17. Fether's Neme (First, Middle, Last) | | | 18. Mother's Nem | e (First, Middle, | | |
| Vai | Vold b Mente urked urked | ToE | James Oscar Jaco | | | Ida E. | Bunne | r | |
| Maryland | nd 2 sho lith end 17 is me traume | | 19e. Intorment's Neme/Reletionship (Type, Print) Clayton Jaco Jr., son | | Meiling Address (Street) 04 01d Wa | | | | Stete, Zip Code) horpe, Md.212 |
| imore | Pages 1 a nent of He int: If Nem iny or othe | | PE DOUGL S CLOUMINGTON 3 CHANGAG LIGHT STATE | | Disposition (Name of y, cremetory or other ple | | Dete /13/96 | | city or Town, Stete more, Marylan |
| 8 | Departs Departs Imports any inju | | 21. Signatural & Funeral Service Licensee | | 22. Neme end Addre | ess of Fecility Funeral | Ноте | Inc | Arbutus 21227 |
| É | | | 23a. Part 1. Enter the disease, or complications that caused the dec shock, or heart failure. List only one ceuse on each line. | eth. Do n | not enter the mode of dyin | ng, such es cardlec | or respiretory e | rest, | Approximete Intervel Between |
| и | Physician /Medical Examiner | | Immediate Ceuse (Final disease or condition resulting in deeth) | tive | Heart | faile | | | Onset and Death |
| | ruted of | Examiner | Sequentle the list conditions | w | Men | dise | ORE | | 15/2 |
| 68760, | tificate be executed in physician and as the burial-transit | cal Ex | Sequentially list conditions if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events | D | Millet | ns | | | 15/2 |
| Box 68 | 5 06 | Physician/Medical | resulting in death) Last | | onsequence of): | adio V | anc a | lisear | 1592 |
| | deeth he atten | sich | Pert II. Other significant conditions contributing to death but not re- | suiting in | the underlying cause give | en in Part I. | 23b. Did 1 | obacco use con | tribute to the cause of death? |
| s, P.O. | v requires that the deeth cer been signed by the attendin should be detached for use | by Phy | hypotension | | | | 10 | Yes 2□No | 3 □ Probably 4 □ Onknown |
| of Vital Records, | aw requires as been sign 2 should be | Completed | Periphual New | wp | altry | | | en eutopsy med? | 24b. Were eutopsy findings evailable prior to completion of cause of death? |
| <u> </u> | sician: The law certificate hes t lirector, page 2 s | Com | / | V | 0 | | 101 | res 2 No | 1 Yes 2 No |
| Vita | clan: entific ector, | Be | 25. Wes case referred to medical examiner? | | low | 28. Piece ot Deet | - | | |
| ō | Physician: rthis certific iral director, | - To | 1 ☐ Yes 2 ☐ Mo Hospitel: 1 ☐ tnpatient 2 ☐ 27. Menngr of Deeth 28s. Dete of Injury. | 28b. T | ime of 28c Injur | 4 LE Nursing Ho | | tence 6 Othe | |
| 0 | Attending In death. actor: After by the funer | tlor | 1 Dreading (Month, Dey Yeer) 2 ☐ Accident investigation | | ijury Woi | k? Yes 2 □ No | | out injury coods. | |
| | of or Attendi | Certification: | 3 Sulcide 6 Could not be determined 28e. Piece of Injury - At the building, etc. (Special Could not be determined building, etc. (Special Could not be determined building). | nome, fer | m, street, tectory, office | | 28t. Location (5 City or Tox | Street end Numbe m, Stete) | or or Rural Route Number, |
| | To the Hospital or Attending Physician: thin 24 hours elfer death To the Funeral Director: After this certific completely filled in by the funeral director, | edical | 29e. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knickers on the basis of examiner: On the basis of examiner and menner steted. | owledge, etion end | deeth occurred at the tir l/or investigetion, in my o | ne, dete end piece, pinion, deeth occurr | end due to the ced at the time, | cause(s) end mar dete end plece, e | ner as stated. nd due to the cause(s) |
| N | To the To the Com | 2 | 29b. Signeture end title of certifier Roay | > | 29c. Licens | 31322 | | - | (Month, Dey, Year) 0 196 |
| | 26 | - | 30. Neme end eddress ot person who completed cause ot deeth (ite | m 23e) (| Type, Print) | | | 212 | 228 |
| | Sta | te | Pradeep Garg, M.D. 724 31. Dete tiled (Month, Dey, Year) FFR 1 2 1000 | Mai | den Choic | e Lane | Catons | ville, | Maryland |

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State of Maryland / Department of Health and Mental Hygiene

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| - | | | | | | Certifica | ate of | Death | Re | og. No. | 0 | UJ | 301 |
|---------------------|--|----------------|---|---|-----------------------------|--------------------------------|---------------------------|--|---------------------------------------|--------------------------|--------------------------|----------------------------|----------------|
| | Dharalai | | 1. Decedant's Nama (First, Middla, La | st) | | | | | 2. Data of Death | | Yaar | 3. Tim | na of Death |
| | Physici /Medi | | George | J. | | JULIAN | 10 | | Februar | | | 11: | 20 am |
| | Examir | | 4a. Facility Nama (If not institution, give | a street and number) | | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | |
| | | | Frankl <u>i</u> .n | | | | | Balt | | Balt: | imore | Cou | inty |
| | Funeral | | 5. Social Security Number 6. S | DAM OF F | In yrs. last birtl | rs. If Unc | dar 1 Yaar ns Days | If Under 24 Hrs Hours Min. | . (Month, Day, | | 9. Birthp | placa (Stantry) | ata or Foraign |
| | Director | | 213-07-3117 Usuai Rasidance of Decedant | 83 | | 13. | | | 10-20- | 1912 | It | ; a 1 y | |
| | yland | | 10a. State 10b. County | 10 | 0c. City, Town | | | | | | 1 | Od. insid | la City Limits |
| | Mar Mar | tor | Md. | | Balt | imore | | | | | | 1430 | Yas 2□No |
| | or 28 | Director | 10e. Street and Number | | | 10f. 2 | Zip Coda | | 10 | og. Citizan of \ | What Cour | ntry? | |
| | 23a | | 635 S. Lehi | gh Street | • | | | 21224 | | U.S | . A . | | |
| | or dea | Funeral | 11. Marital Status | 12. Was Dacedant Eva Armed Forcas? | ar in U,S. | 13. Was Dad If Yas, s | cedant of I pecify Cub | lispanic Origin? (S an, Maxican, Puar | Specify Yas or No- to Rican, atc.) | | e - Amaric ck, Whita, | | n, |
| 20 | filed within 72 hours after death with the Maryland thysiene. ther than "natural", or Nerns 23a or 28a-f show ont, the Medical Examinet must be norfiled at | by F | 1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | t Tyas 2 □ No If Yas, Giva | | | 2-140 | Specify: | | Specify | | nite | |
| 8 | tural | Pa | 15. Decedent's Ed | | 1942 | Decedant's Us | sual Occur | nation | | 16b. Kind of B | uclosec@o | dueto | |
| Maryland 21215-0020 | n n n | Completed | (Specify only highast gra Elamantary/Secondary (0-12) | ada complated) Collega (1-4or 5+) | | Giva kind of 1 lifa. DO NOT | work done | during most of wo. | rking | 100174110 01 01 | | a do di y | |
| 7 | d wit | E | 8th | College (1-401 5+) | | Aut | o In | spector | - | Gen. | Moto | ors | |
| nd | al Hygiral other | Be | 17. Fathar's Nama (First, Middle, Last, |) | | | | 18. Mothar's Na | ma (First, Middla, N | faidan Suman | 18) | | |
| Ya | should be ind Mental in marked or umatic eve | 5 | Vincenzo | Julian | 10 | | | Fi | lomena | Bocen | .0 | | |
| Mar | l 2 sh and ls ma reum | | 19a. Informant's Name/Ralationship (| Type, Print) | 19b. | Mailing Addre | ess (Streat | and Number or R | ural Routa Number, | City or Town, | Stata, Zip | Code) | |
| | s 1 and 2 should be filed within 72 hours after death with the Manylan I Health and Mental Hygiene. I tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be northed at | | Lillian Jul | iano | 20b Place of | 35 S | Leh | igh Str | cet, Ba | 1to, | Md. | 2.1 | 224 |
| altimore, | 0 0 | | 1 ☐ Buriai ZG Gremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specific | Ramoval trom Stata | cematary | , cramatory o | r othar pla | ce) | 2/10/06 | Pa1 | t o | Md. | a |
| | permit. Page Department Important: If any Injury or once. | | 21. Signature of Funaral Sarvice Licer | | Green | 22 Mama | and Addre | on of English | 2/10/96 | | | | |
| B | Depariment of the population o | | Merci bz | anner | | Jose | eph | N. Zann | ins; Sp | nklin Fun | gršt | / _H o | 1224 me |
| | | | 23a. Part1. Enter the disease, or shock, or heart tailura. List | blications that caused the | a daath. Do no | ot enter the m | ode ot dyi | ng, such as cardia | c or raspiratory arre | est, | | Approxi | Batween |
| | Physician // Medical | | | | | | | | | | | Onset a | and Death |
| | Examiner | | Immediata Causa (Finel disease or condition rasulting in death) | a. Septicemi | ia | | | | | | | 2 we | eeks |
| | 2000 | ē | | | a to (or as a co | | ot): | | | | i | | |
| | d ansit | Examiner | Sequentially list conditions | b. Aspiratio | on Pneu | | ·n· | | | | 1 | | |
| o, | an an | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | 500 | u 10 (01 us u 01 | Albequarice o | , | | | | 1 | | |
| 68760, | death certificate be axecuted e attending physician and of for use as the bunal-transit | Medical | Cause (Diseasa or Injury thet initieted evants resulting in death) Last | C. Due | a to (or as a co | nsequance of | f): | | | | | | |
| | e as t | | | d | | | | | | | | | |
| Box | eath cer attendir | lan | | V | | | | | | | | | |
| р. О. | res that the deligned by the a | Physician/ | Part II. Other significant conditions of | ontributing to death but n | ot rasuiting in | tha undarlying | g causa gi | an in Part I. | 23b. Dtd tol | bacco use co | ntribute to |) the cau | uee of death? |
| | law requires that the as been signed by th 2 should be detache | | Athersclerotic va | ascular dise | ease | | | | 1 🗆 Yı | 8 2□ No | 3 Prot | bably | 4 Unknown |
| Hecords , | uires ald be | d by | | | | | | | 24a. Was ar | autopsy | 24b. W | ara autor | osy tindings |
| ဝ္ပ | w require s been si s should I | Set | Gangrenous foot | | | | | | perlorm | ned? | COI | aliable prompletion death? | of causa |
| | 0 - 6 | Completed | | | | | | | 1□ Ya | s 21 No | | ⊒ Yas | 2 No |
| Vitai | iclan: Th certificata irector, pa | BeC | 25. Was casa ratarred to medicel | | | | | 26. Piace of Dec | ath (Check only one | | | | |
| 0 | nysle is ce direc | 70 | axa <i>m</i> inar? 1 □ Yas 2⊠ No | Hospital: 1 ☑ Inpatiant | 2 ER/Out | patient 3 | DOA Ott | nar: 4 Nursing H | loma 5□ Rasida | nce 6 □Oth | ar (Specifi | y) | |
| ב | Attending Physician: or death. ector: After this certific by the funeral director, | | 27. Mannar of Death 1 ☑ Natural 5 ☐ Panding | 28a. Data of injury (Month, Day Ye | gar) 28b. Ti | ury | 28c. Inju | y at rk? | 28d. Dascribe ho | w injury occur | red | | |
| 200 | tendi jeath tor: A | cat | 2 Accident invastigation 3 Suicide 6 Could not be | | | М | 1.5 | Yas 2□No | | | | TAINE | |
| DIVISION | tal or Attending Physics after death. al Director: After this or led in by the funeral dire | Certification: | 4 Homicida datarmined | 28a. Placa of injury building, atc. (S | - At homa, tarr Specify) | n, street, tact | ory, office | | 28f. Location (Str City or Town | eet and Numb , State) | er or Hura | II Houte, I | Number, |
| | opital nours | | 29a. Certifier 1⊠ Certifying Ph | yelcian: To tha best of m | v knowledge. | deeth occurre | ed at the ti | me, dete end piece | and due to the ca | use(s) and me | enner as si | tated. | |
| | P Pur | edical | (Check only 2 Medical Examone) | niner: On the basis of axe and mannar stated | amination and/ | or Invastigation | on, in my o | pinion, deeth occu | urred at tha tima, da | ta and place, | end dua to | tha cau | 88(8) |
| | To the Hospital or a within 24 hours after To the Funeral Director Completely filled in the completely filled in the complete of the complete | × | 29b. Signatura and title of certifiar | _ | | 2 | 9c. Licans | a number | 29 | d. Deta signe | d (Month, | Day, Yes | ar) |
| | | | bant | Eul. D | n. el | D | 25 | Ethele | - | 12/9/51 | • | | |
| | 17 | | 30. Nama and address of person who | complated causa of daath | h (item 23a) (T | ype, Print) | | | 1 | 1 | | | |
| | 10 | | Stuart Willes, M | | | en Bou | leva | rd, Balt | imore, M | aryland | 1 21 | 239 | |
| | Sta Registr | | FEB 1 3 1996 | 32. Registrate | Signatura | | | | | | | | |
| | 3 | | / / | F . | | | | | | | | | |

DHMH 16 Rev 6/95

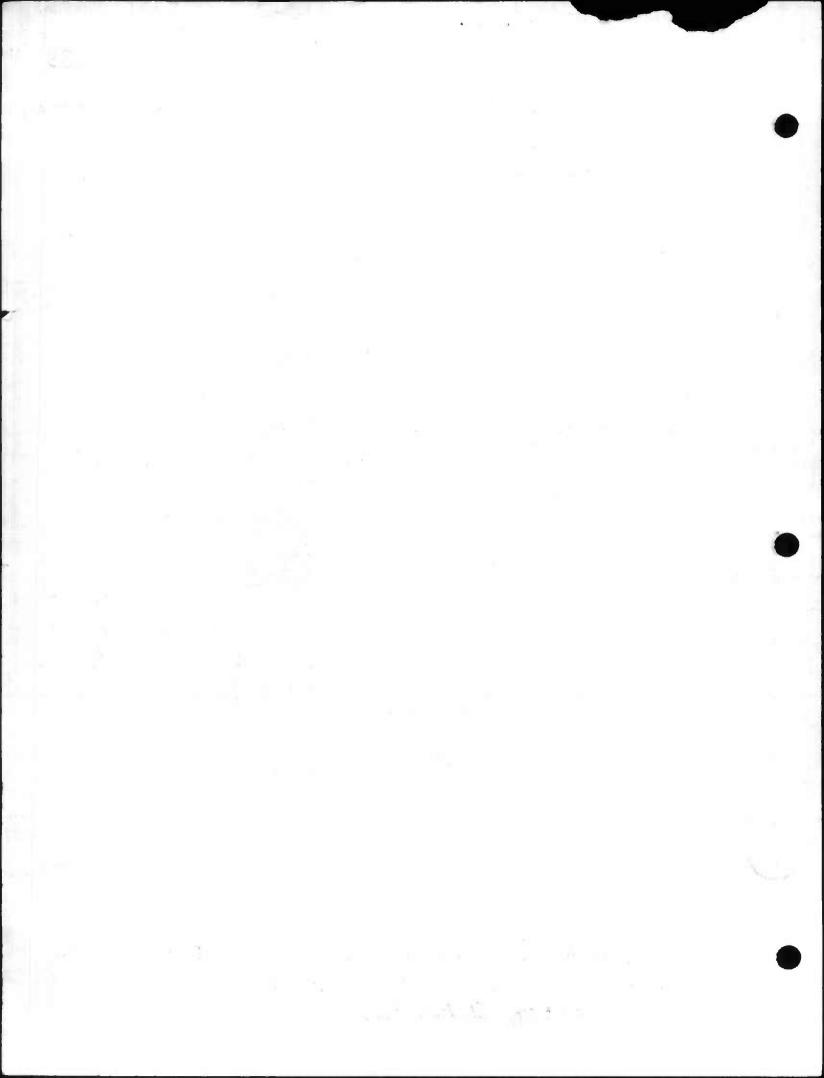
a section and the section and

G-732 2/13/96 t.t

ITEM: 7. PER F..H FILM Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03562

| _ | | | Certificate of Death | Re | g. Nc. | |
|-----------------|--|---------------------|--|--|------------------|---|
| | Physic /Medi | cal | 1. Decedant's Name (First, Middle, Last) Limberty Jones | 2. Data of Death Month Februar | y 9 19 | Year 842/AN |
| | Exami | ner | 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Lo | | 4c. County o | More. |
| | Funeral Director | | 5. Sociel Security Number 6. Sex 1 | 8. Dete of Birth Month, Day, July 2 | | 9. Birthpieca (Stata or Foreign Country) Md |
| 020 | 72 hours efter death with the Maryland natural; or items 23s or 28s-1 show lical Examine, must be notified at | by Funeral Director | 10a. Stata 10b. County 10c. City, Town or Location 10a. Stata 10b. County 10c. City, Town or Location 10b. Street and Number 10f. Zip Coda 11. Marital Status 12. Was Decedant Ever In U.S. Armed Forces? 1 | | | 10d. Insida City Limits 1 □ Yas 2 □ No nat Country? S + A - American Indian, White, atc. Black |
| ind 2121 | be filed within Ital Hygiene. Id other than " event, the Ma | To Be Completed | 15. Decedant's Education (Specify only highest grada completed) Elamentery/Secondary (0-12) Ath Grade 17. Father's Name (First, Middle, Last) 18. Decedant's Usual Occupation (Giva kind of work dona during most of works life. DO NOT usa retired) Assistant Manage 18. Mother's Name Parelle Parelle | ing (First, Middle, N | 25 | do Co. |
| imore, | permit. Pages 1 and 2 should Department of Heelth and Mer Important: If item 27 is merke any injury or other traumatic once. | | 19a. Informent's Neme/Relationship (Type, Print) Bevery Jones - Mother 53 /5 Grst Aver 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removel from Stata 4 Donation 5 Other (Specify) 21. Signature of Funarel Sarvice Licensee 22. Nama and Addrass of Fecility March 50 0 | rue le | Ba No, 1 | rate, Zip Code) Lity or Town, Stata LIS town, md 2121 LIE Balto, Ma |
| | Physician /Medical Examiner | iner | 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Lischemic Encephalo pathy | or respiratory arre | ist, | Approximeta Interval Between Onset and Death 6 hours 5 weeks |
| • | n certificate be executed anding physician and use as the burial-transit | In/Medical Examiner | Sequentially list conditions, Dua to (or as a consequence of): | cardra | | 5 weeks 19 Years |
| , P.O. B | requires that the death seen signed by the atter hould be detached for t | y Physicia | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did to | V | ribute to the cause of death |
| 6 | 2 s E | Completed by | | 24a. Was ar perform | | 24b. Were autopsy findings available prior to completion of cause of death? |
| | cartificate | o Be | 25. Was case referred to medical axaminar? 1 Yes 2 No Solution 2 ER/Outpatient 3 DOA Other: 4 Nursing House | 1 ☐ Ya h (Check only one me 5 ☐ Resida | 2) | 1 Yes 2 No |
| vieton of Vital | tor: After thi | Certification: T | 27. Mannar of Death 1 Natural 5 Panding (Month, Day Year) 2 Accident invastigation 3 Suicide 6 Could not be | 28d. Dascribe ho | w Injury occurre | |
| 5 | to the Hospital within 24 hours after To the Funeral Direct completely filled in by | Medical Certi | 29a. Certiflar (Check only one) Certifying Physician: To tha best of my knowledge, daath occurred at tha time, date and place, 2 Medical Examiner: On the bests of axaminetion end/or investigation, in my opinion, deeth occurred and mannar stated. | City or Town and due to the ca red at tha time, da | usa(s) and man | ner as stated. ad due to the cause(s) |
| | o o o | - | 29b. Signatura and titla of certifier 29c. Licanse number 29c. Licanse number 39696 30. Nama and addrass of person who complated eausa of death (Negro 23a) (Type, Print) | | ebruar | (Month, Day, Year) 19, 1996 |
| | 2 | | DEBORAH ANN SCHWENGEL SINAI HOS | PITAL | | |
| | Sta Registi | | 31. Data filed (Month, Day, Year) 32. Ragisfar's Signature FEB 1 3 1996 Jana Bandun Randell | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth

| Physician |
|-----------|
| /Medical |
| Examiner |

1. Decedent's Name (First, Middle, Last)

9:00 P.M.

Month (Psy JONES HELEN Μ. 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE BALTIMORE 1426 MADISON AVENUE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** Months 10 M AFT 82 218-30-5031 Yrs Director MARYLAND 06/03/1913 Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at MYes 2□No Director MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21217 U.S.A. 1426 MADISON AVENUE permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hydiene. Important: If then 27 is marked other than "natural", or Herna 23e any injury or other traumatic event, the Mental Funeral Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ Wo If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ yNo Specify. by Specify: BLACK 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SCHOOL SYSTEM **JANITOR** 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be MARY H. Jones 2 JOHN H. JONES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2904 VIRGINIA AVENUE BALTIMORE, MARYLAND 21215 REV. OGDEN JONES (GRANDSON) 20b. Plece of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MOUNT ZION CEMETERY 2/10/96 LANSDOWNE, MARYLAND 21. Signeture of Funerel Service Licenses ESTEP BROTHERS FUNERAL HOME PA. 23e. Pert1. Enter 11 disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or he in feilure. List only one cause on each line. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217 **Physician** ATHERO SCIPLATIC CORTNARY VASCULAR DISEASE) Immediete Cause (Finel diseese or condition resulting In deeth) /Medical Examiner Examiner or Attending Physician: The lew requires that the death certificate be executed after death. Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last physicien and the burial-tran Division of Vital Records, P.O. Box 68760, by Physician/Medical as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? certificate hes b director, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 15 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this huneral 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 16ENetural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, dete and placa, end due to the ceuse(s) end manner steted. 29e. Certifler (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) her hos

232700

300 ARMORY PLACE BALTIMORE MD 21201

State Registrar

ANWAR

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

KHOWAR MO

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 6 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physiclan** Month Year 01 2 Helen Victoria Jacobson 02 12 96 aw /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County General Hospital Westminster Carroll County If Under 1 Yaar If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth (Month Day, May 0, 1) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X F Yrs. 199-07-3419 Director Pennsylvania Usuai Rasidence ot Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Madical Examinar must be notified at 1 Yas 2 No Frederick Emmitsburg Director 10e. Street and Number 10f. Zip Coda permit. Pages 1 and 2 should be filled within 72 hours efter death with a Department of Heelth and Mental Hygiene. Important: If frem 27 is marked other than "natural", or flems 23a ~ ? any injury or other treumetic event, the advance. 10g. Citizen of What Country? U.S.A. 21727 112 Welty Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Giva Year or Dates: 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☑ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Cook Food Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be Yingling Stoner 2 (Unknown) (Unknown) 19a. Intormant's Name/Relationship (Type, Print) 19b. Malling Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 1 Barata Ct. Apt. 103 Timonium, MD 21093 Mr. Nicholas Jacobson (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burlai 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 2/14/96 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 Sulun Yau 23a. Part1. Enter the diseasa, or complications that between the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or open line. Approximata Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. Acute Mys Cardial
Due to (or as a consequence of): 10 day Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completally filled in by the funeral director, page 2 should be deteched for use as the burdal-transit completally filled in by the funeral director, page 2 should be deteched for use as the burdal-transit burial-transit Sequentially ilst conditions, if any, leading to immediata causa. Enter Underlying Causa (Disaase or injury that initiated events resulting in daath) Last Dua to (or as a consequence ot) physician is the burial Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Ventricular tacky Curdia þ 24b. Wera autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed Acute Renal failon 1 Yes 2 ANo 1 ☐ Yes 2 ☐ No 25. Was casa reterred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 2 No 1 tnpatient 3 DOA 2 ER/Outpatient 27. Manger of Death 26a. Data of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 □ Yas 2 □ No 2 Accident 6 Could not be datermined 3 Suicide 28e. Piace of fnjury - At home, tarm, street, tactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homloide 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and manner as stated.
2 Medicat Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to tha causa(s) and manner stated. Medical 29a, Cartifier 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) NUSIF Nokhtar MO D35711 2 112 196. 30. Name and address of person who completed cause of death (Item 23a), (Type, Print)
Mokhtar Nasir, 200 Memonal Avenue Westminster, MD 21157 31. Data filad (Month, Day, Year) Registrar's Signature State 3 1996 Registrar

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DHMH 16 Rev 6/95

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| E HISTITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | Executed DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should | filed within 72 hours after death with the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal. | DRTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ence. |
|--|---|--|---|
| QL QL | TO THE | be filed | IMPOF |

| 1 - STATE REGISTRAR | STATE OF MARYL | | ENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | | | | | |
|--|---|--|--|---|--------------------------|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle AN GEL A | | | | 2. DATE OF DEATH DAY FEB // | YEAR 1996 | 3. TIME OF DEATN 02:17A M | | | | | | |
| 4. SOCIAL SECURITY NUMBER 220 -01 - 259 9a. FACILITY NAME (If not institution | 5. SEX 8. AGE (| YRS. MON | INDER 1 YEAR IF UNDER 24 HRS. THE DAYS HOURS MIN. CITY, TOWN OR LOCATION OF D | 7. DATE OF BIRTH (Month, Day, Year) MARCH 21, / | nth, Day, Year) Country) | | | | | | | |
| CHURCH RESIDENCE OF DECEDE | Hosp. | | BALTIMORE | | NA | | | | | | | |
| | NA | | WN OR LOCATION TIMORE | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | |
| TOO. STREET AND NUMBER 525 5 D 11. MARIYAL STATUS | PECKER AVE. | | 101. ZIP CODE 21224 | | U · S | what country? | | | | | | |
| 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II | 2 XNO | 13. WAS DECENDENT OF NISPA If yee, specify Cuben, Maxic 1 YES 2 NO Speci | en, Puerto Ricen, etc.) | Sne | CE — American Indian, ck, White, atc. | | | | | | |
| Wasally and Make | 'S EDUCATION at grade completed) College (1-4 or 5+) | 16a, DECEDENT'S USU. (Give kind of work of life. Do NOT use reti | done during most of working red.) | 166. KIND OF BUSIN | ESS/INDUSTRY | | | | | | | |
| JOSEPH | 17. FATNER'S NAME (First, Middle, Lost) 18. MOTHER'S NAME (First, Middle, Maiden Surname) TOSEPH CICHOWICZ CATHERINE PUWA | | | | | | | | | | | |
| 2 JOHN C. H | 196. INFORMANT'S NAME/(Type/Print) 196. MAILING ADDRESS (Street and Number or Fourth Route Number, City or Town, State, Zip Code) 196. MAILING ADDRESS (Street and Number or Fourth Route Number, City or Town, State, Zip Code) 525 S. DECKER AVE BALTO-, MD. 21224 | | | | | | | | | | | |
| 20s. METNOD OF DISPOSITION 1 Description of Control of | Removal from State centry) | PLACE AND DATE OF DI petery crematory or other of | | | | Town, State 90 · MD - | | | | | | |
| > Thomas | 2 - Skan | le f. | SKARDA F. | 4. BALTO. | | . 21224 | | | | | | |
| 23. PART I. Enter the disease ahock, or heert for IMMEDIATE CAUSE (Final disease or condition resulting in death) | es, or complications that cause allure. Cist only one cause on a a | Myocardu | el Infanction | r. | | Approximate Interval Between Onset and Death | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b. Alherosclerotic Cardio Vascular Les ease Coron any Arlery Due to (or as a consequence or): | | | | | | | | | | | |
| | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | | | | | | | | |
| DID TOBACCO USE C | CONTRIBUTE TO CAUSE O | F DEATH YES | | IN 🗆 | | | | | | | | |
| EXAMINER? | HOSPITAL: 1 Dinpetlent 2 ER/Out | | HER: Nursing Nome 5 Realdence | 8 Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pendir 2 Accident Investi | | 26b. TIME OF INJURY | 26c. INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRISE NOW INJ | URY OCCURED | | | | | | | |
| 3 Suicide 6 Could | not be building, etc. (Soe | f — At home, farm, stree clfy) | t, factory, office | 28f. LOCATION (Street and City or Town, State) | d Number or Rura | I Route Number, | | | | | | |
| CONSCIN ONLY | PHYSICIAN: To the best of my know XAMINER: On the basis of exemination | | | | | e(s) and manner as stated. | | | | | | |
| 296. SIGNATURE AND TITLE OF CL | ani ma | | | JMSER 26594 | | ED (Month, Dey, Year) 11 1996 | | | | | | |
| RIAZ BOKH | | 100 N. B | ROADWAY | 13ALTIMOI | RE Mi | 2/23/ | | | | | | |
| FEB 1 3 1996 | 2. RECISTRARY SIGN | ATURE | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

| Certificate | of | Death | |
|-------------|----|-------|--|

| Physician |
|-----------|
| /Medical |
| Examiner |

1. Decedent's Nema (First, Middle, Last)

2. Dete of Deeth Month

Funeral Director

with the Maryland 28a-f show Directo ò Nerns 23a Funeral þ Completed

treumatic event, the Medical Examiner must be nutified at Pages 1 and 2 should be filed within 72 hours after death sent of Health and Mental Hygiene.
nt: If Item 27 Is marked other than "naturel", or Items 23.

altimore, Maryland 21215-0020

Depertment of Health in Important: If Item 27 is any injury or other tre **Physician** /Medicai Examiner

Examiner

Physician/Medical

à

Completed

Be

ပ္

Certification:

Medical

The law requires that the death certificate be executed physician s the burial Division of Vital Records, P.O. Box 68760, attending p signed by the certificata has t ospital or Attending Physician: director this funeral After octor: / filled in by after Funerel

11,1996 5:30 PM The 1 ma KRAUSE February 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rossville Baltimore Months Days Hours Min. 8. Deta of Birth (Month, Par. 1913) 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign 10 M 2 F Maryland 212-42-6770 Yrs. Usuel Residence of Decedent 10e. Stete 10h County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2/20No Maryland Baltimore Essex 10f. Zip Coda 10e. Straet and Numbar 10g. Citizen of Whet Country? 320 Miles Road 21221 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, Whita, atc. 11. Maritel Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 🗷 No If Yes, Giva Yaar or Detes: 1 ☐ Yas 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Eiementery/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Sumema) Thomas Tice Nellie Joyce 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3 Eyring Avenue Essex, MD. 21221 George Krause 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Removel from State Oak Lawn Cemetery 2/14/1996 Baltimore, Co. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarel Service Licansee 22. Name end Addrass of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Baltimore, MD. 21221 Paul . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) Congestive Heart Failure 5 Hours Due to (or es a consequence of): b. Metastatic Colon Cancer Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in deeth) Lest Due to (or es e consequence of): Atrial Fibrillation Due to (or es e consequence of) Anemia Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Deep Venous Thrombosis 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed?

1 Yes

1 □ Yes 2 □ No

25. Wes case referred to medical 1 Yes 2 No

5 Pending Investigation

6 Could not be

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

28. Plece of Deeth (Check only one)

2₽No

29a, Certifier

27. Menner of Deeth

1 Neturel

2 Accident

3 ☐ Suicide

4 Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to tha ceusa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted.

29b. Signatura and title of certifiar

29c. Licansa number

29d. Data signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

30. Neme end eddress of parson who completed cause of deeth (Item 23e) (Typa, Print)

John Loh MD. 9000 Franklin Square Dr. Balto, Md. 21237

State Registrar

31. Dete filed (Month, Day, Year) FEB 1 3 1996



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygien

03567 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth FEBRUARY 8, 1996 **Physician** 16:30 P JOHN ALBERT LLOYD /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not Institution, give street end number) 4c. County of Death Examiner St. Agnes Hospital Baltimore N/A Hours Min. 8. Dete of Birth (Month, Dey, Year) 1924 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1**X** M 2□ F Months 214 22 5485 71 Maryland Yrs Director Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after death with the Maryland nant of Haalth and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumsite event, or Medical Exammer must be nomited at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Directo Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21227 137 Clyde Avenue U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 X Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 Ho Specify: Specify: White ٥ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown N/A unknown 17. Fether's Neme (First, Middle, Lest) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Marie Byrnes Walter Lloyd 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Lloyd 137 Clyde Avenue Baltimore, Maryland 21227 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burlel 2 【Cremetion 3 ☐ Removel from Stete Department of Important: If any injury or once. 2/12/96 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signeture of Funarel Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. namuouy 4001 Ritchie Highway Baltimore, Md. 21225 23a, Mrt1. Entar the disease, of complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. **Physician** Immadiate Causa (Finel diseese or condition resulting in deeth) Myocardia / In furction /Medical 30 minutes Examiner Examiner Zyears attending physician and for use as the burial-transit law requires that the death certificate be asscuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initieted events resulting in daath) Last Diyision of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be datac uluconas 24b. Were autopsy findings avellable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No 208-No this certificata To the Hospital or Attending Physician: within 24 hobe attachash.

To the Funeral Director: After this cartifics complately filled in by the funeral director, 25. Wes case referred to medical exeminar? 28. Placa of Deeth (Check only one) 1 ☐ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred 5 Pending investigation La Naturel 1 Yes 2 No 2 Accident 3 Suicide 8 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, straet, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowladge, daath occurred et the time, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number February 8, 1996 eunt4/ 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 900 Cation Avenue BATIMORE Maryland 21229 H. SCRULLES KEVIN MI 31. Dete filed (Month, Day, Year) FEB 1 3 1996 32. Registrer's Signeture State Registrar

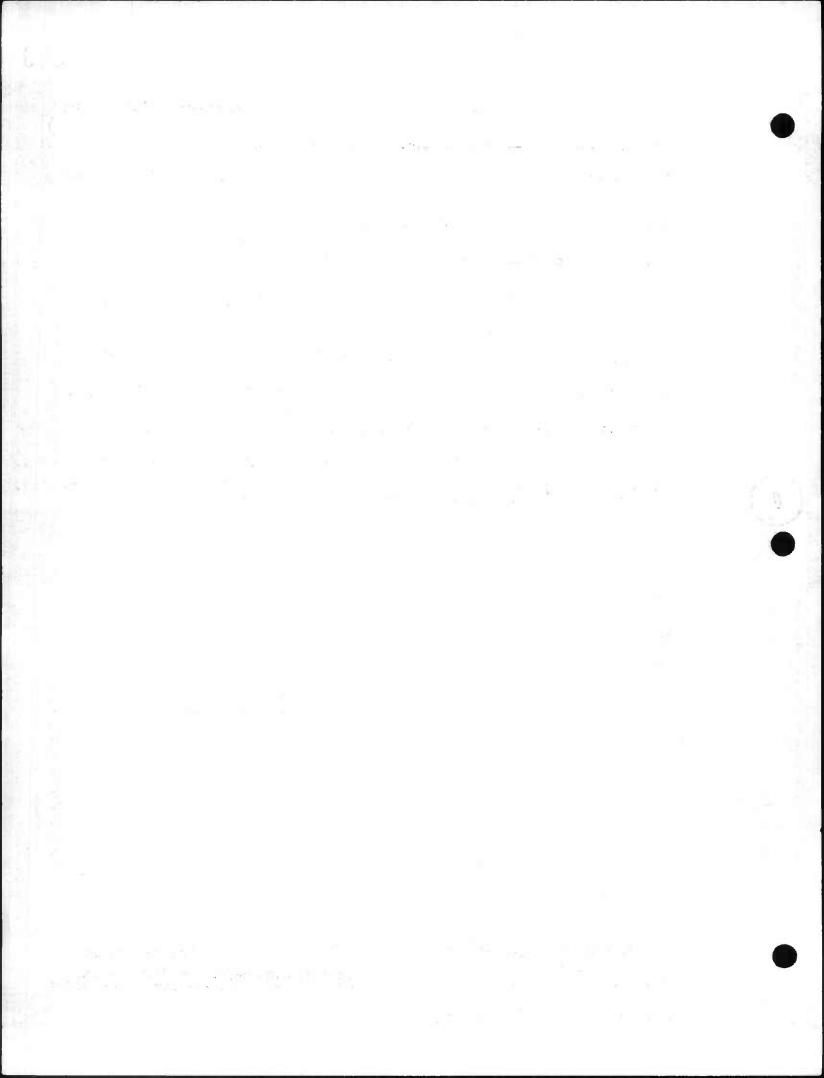
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State of Maryland / Department of Health and Mental Hygie 96 03568

| | | | | | | | Cei | rtificate | of i | Death | | | Reg. | | | |
|-------------|---|------------------|---|---|----------------------|------------------|--------------------|--------------------------------|-------|-----------------|------------|---------------------------|------------------|---------------|------------|--|
| | | | 1. Decedent's Nama (F | irst, Middla, La | st) | | | | | | | 2. Date of D | | | V | 3. Time of Leath |
| | Physic /Medi | | Paul Mar | ion | I | ozuk | | | | | | Februa | ary | 7, 199 | 96 | 8:50 pm |
| | Exami | | 4a. Facility Nama (If no | | e street and nu | um <i>ber)</i> | | | - | 4b. City, Tov | vn, or Loc | cation of Dea | ith 4 | c. County | of Death | |
| 1 | | | Johns Hopk | cins Ba | wiew M | fedical | Center | | | Balti | more | | | | | |
| т | Funeral | П | 5. Social Security Numb | | | | . last birthday) | If Undar 1 Y | | If Under 2 | | 8. Date of B (Month, L | irth | | 9. Birtho | place (State or Foreign |
| | Director | | 220-18-76 | 512 | M 2□ F | 69 | Yrs. | Months D | ays | Hours | Min. | (Month, E | 7 / 1 C | 26 | Cour | MD COM |
| | | | Usual Rasidence of De | | | | | | | | | 0/1 | / 13 | 20 | | 1112 |
| | ahow ahow | | 10a. State 10 | b. County | | 10c. C | ity, Town or Lo | cation | | | | | | | 1 | 0d. Inside City Limits |
| | Mar | to | Md. | | | В | altim | ore | | | | | | | | 1 Tyes 2 □ No |
| | r 28 | Funeral Director | 10e. Street and Numbe | r | | | | 10f. Zip Co | de | | | | 10g. C | itizen of \ | What Cour | ntry? |
| | 3a o | 0 | 3512 E. | Fairm | ount : | Augnua | | 2.1 | . 2: | 2.4 | | | т. | C 3 | | |
| | deeti | Jer | 11. Marital Status | LUILI | 12. Was Dec | edant Ever in l | | Was Decedent | of H | lispanic Orlo | in? (Spe | cify Yas or N | | SA 14. Rac | e - Amaric | an Indian, |
| 0 | r lter | Ē | Armed Forces? If Yas, speci | | | | | | Cuba | an, Maxican, | Puerto P | Rican, etc.) | | | ck, White, | |
| 21215-0020 | be filed within 72 hours efter deeth with the Maryland stal Hygiene. I other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | by | 3 ☐ Widowed 4 ☐ | | fres, G Yaar or [| ive Detes: | | 1□ Yes 2√2 | No | Specify: | | 1/43 3/46 | to | Specify | Wh: | ite |
| P | 2 hor | 8 | 15. | Decedent's Ed | ducation | | 16a. Deced | dent's Usual O | ccup | ation | | | 16b. | Kind of B | usiness/in | dustry |
| 7 | nin 7 | Completed | (Specify o | only highest gra | ida completed) | | (Give | kind of work d DO NOT use n | one d | during most | of workin | g | 1 | | | |
| 21, | filed within Hygiene. ther than | E | Elemantary/Seconda | | | (1-4or 5+) | Har | dwood | F | inis | her | | Kn | qqi | & C |) . |
| | H Hyg | | 17. Fathar's Nama (Firs | st, Middle, Last) |) | | | | Ť | | | (First, Middl | | | | |
| lan | Mental Mental arked o | To Be | Paul Loz | uk | | | | | | Do | (| Doro | t hw | Mi | chal | levi |
| Maryland | EVEE | F | 19a. Informant's Name | | Type Print) | | 19h Mailir | ng Address (Si | root | | | | | | | |
| N | | | | | | , | | | | | | | | | | |
| œ, | r Health Hem 27 other to | | Mary Lo 20a. Mathod of Disposit | | spous | e) 20b | 351 Plece of Dispo | 2 E. sition (Name of | Fa | irmo | unt | Aven | ue i | Balt | O. I | 1d. 21224 |
| more, | 8025 | | 1 ☑ Buriai 2 ☐ Ci | remation 3 [| | State | connecery, crea | natory or other | prac | 20) | 100 | | | | | |
| 트 | tant dury | | 4 Donation 5 | | | Ga | rrison | 1 Forr | es | st | 2 | /12/9 | 6 B | alt | ımor | e, Count |
| Saj | Definit. Par Department Important: any Injury. | | 21. Signeture of Funera | al Service Licer | 900 | | 22 | . Name and A | ddra | ss of Facility | Jo | seph | N. | Zanı | nino | Jr. F.H |
| T. | 905.00 | | 1/1/2 | rea / | Jan | ned | 26 | 53 S. | C | onkli | | | | | | 21224 |
| | Carlotte. | | 23a. Part1. EnteAthe d | lisease, or com | plications thet | caused the dea | th. Do not ent | er the mode of | dyln | g, such as o | cardiac or | respiratory | arrast, | | | Approximate |
| ١. | Physician | | 23a. Part1. Entarthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, in the cause on each line. | | | | | | | | | | | | | Interval Between Onset and Death |
| а | /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarct Due to (or as a consequence of): | | | | | | | | | | | 36 hours | | |
| | Examiner | | | | | | | | | | | | | 30 Hours | | |
| | | ē | h Hypertension | | | | | | | | | | | | 110280 | |
| | d d ansk | 直 | | | | | | | | | | | | | years | |
| Ć. | entificate be axecuted ding physician and se as the burial-transit | Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | |
| 68760, | sicia bur | Cai | Cause (Disease or Injur | ij 【 | c | Dun to (| | | | | | | | | | |
| 89 | ficet phy s th | edicai | resulting In death) Last | | | Due to (| or as a conseq | uenca or): | | | | | | | | |
| X | 0 2 3 | 3 | | | d | | | | | | | | | | | |
| ď | atte for | cla | D II OH III | | | | | | | | | 1 | | | | |
| Ö | hat the de ad by the deteched | Physician | Part II. Other significan | it conditions o | ontributing to d | leath but not ra | suiting In the u | nderlying caus | e giv | en in Part I. | | | | | | the cause of death? |
| <u>α</u> | ed by detect | | | | | | | | | | | 10 | Yes | 2□ No | 3 Pro | bebly 4 Unknow |
| ds | requires that the seen signed by th hould be detech | 1 by | | | | | | | | | | - | | NT/2 | 0.45 144 | and a standard fladings |
| 0 | been s | Completed | | | | | | | | | | 24a. Wa per | s an autoformad? | opsy | av | ere autopsy findings ailable prior to |
| Records, | 2 S W | du du | | | | | | | | | | | | | of | mpletion of cause death? |
| <u>—</u> | | ő | | | | | | | | | | 1 🗆 | Yes : | No Es | 10 | Yas 2₫No |
| Vital | | Be (| 25. Was case referred t | to medical | | | | | | 28. Piace | of Death | (Check only | ona) | | | |
| > | Physician: this certific ral director, | T0 | examinar? 1 ☐ Yes 2 🛣 No | | Hospital: | Inpatiant 2 | ER/Outpatien | t 3 DOA | Oth | er: 4 Nur | sing Hom | ne 5□Res | sidenca | 8 DOth | ar (Specif | v) |
| of | | | 27. Mannar of Death | | 28a. Date | of Injury | 28b. Time of | 28c. | Injun | | | 8d. Describe | | | | , |
| Ö | ath. :: After e funer | at o | 1 Natural 5 2 ☐ Accidant | Pending Investigation | | ith, Day Year) | Injury | | | k≀ Yes 2 🗆 N | lo | | | | | |
| Division | if or Attending after deeth. Director: After d in by the fune | Certification: | 3 ☐ Suicide 6 | Could not be determined | 28e. Piace | of Injury - At h | ome, farm, str | eet, factory, of | ica | | 2 | 8f. Location | (Street a | nd Numb | er or Rura | Il Route Number, |
| ă | afte Dir | er | 4 Homicide | GOLOITIIIIOG | | ing, etc. (Speci | | , , , , , , , | | | | City or To | | | | |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled In by | | 29a. Certifier | Cartifying Ph | valcian: To the | best of my kno | wiedne deeth | occurred at th | a tin | ne date and | nlace a | nd due to the | a causal | e) and me | annar as s | teted |
| | Pur Fur etely | edical | | Medical Exam | niner: On the b | asis of examina | ation and/or Inv | estigation, in r | ny o | pinion, daath | occurre | d at the time | , date ar | d place, | end due to | the cause(s) |
| | within 2 To the comple | Me | 29b. Signature and title | of certifier | and man | illor stateo. | | 29c. Lie | anso | e number | | | 29d D | ete signe | d (Month | Day, Year) |
| | 5 × 5 00 | | 1014 | Horson | 1 | 2 | | 450 | | | | | | | | |
| | 0 | | 7 00111 | · | | | | - ' | | | | | Feb | ruar | y 8,1 | .996 |
| | 0 | | 30. Name and address of | | _ | se of death (Ite | n 23a) (Type, | OOH | ns | Hopki | ns E | Ayvie | w Me | dica | l Cen | iter |
| | | | WH HO | ogeri | vers | | | 4940 | C | Easter | n Av | e., B | alti | more | , MD | 21224 |
| | Sta | 882111 | 31. Date filed (Month, D | ay, Year) | 32. F | Registrar's Sign | | | | | | | | | | |
| | Registr | ar | FEB1 319 | 196 /1 | in die | terRenda | 4 | | | | | | | | | |



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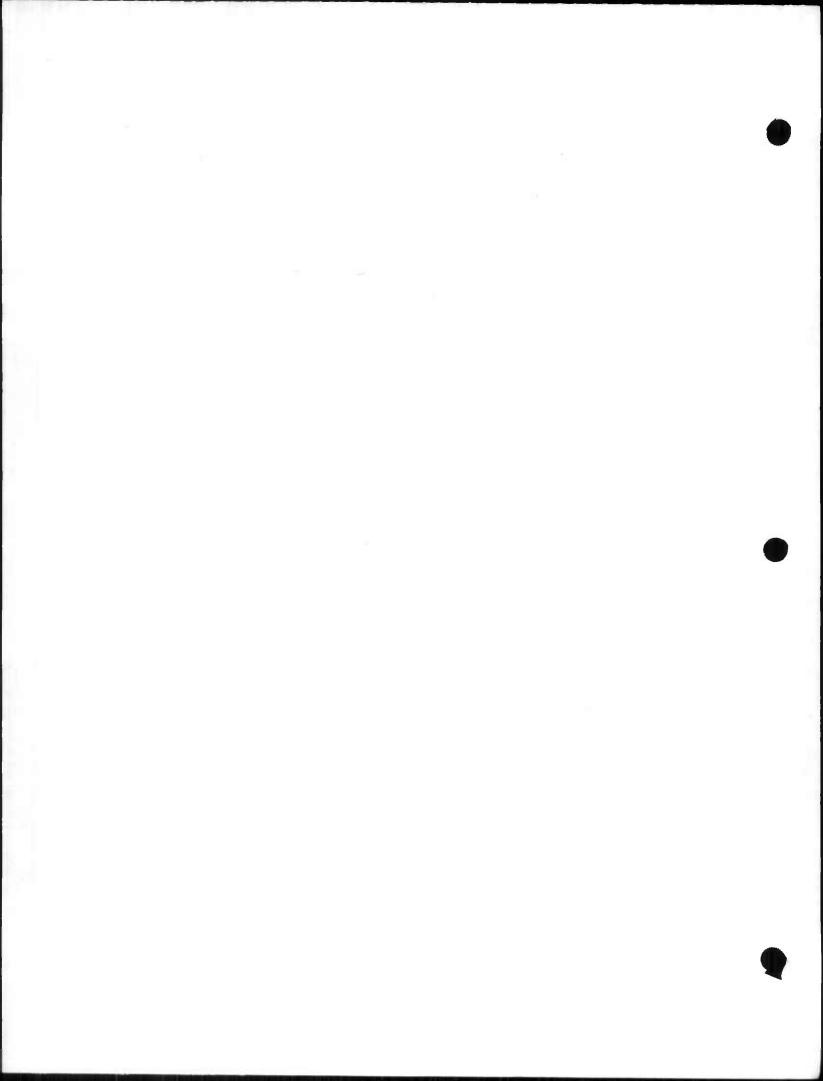
GIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL_OB_AFTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | ENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | | | | | | | |
|------------------|--|--|---|---|---|------------------------------------|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 1 | | | 2. DATE OF DEATH MONTH DAY | YEAR | 3. TIME OF DEATN | | | | | |
| | 5 WOO+ 4. SOCIAL SECURITY NUMBER | 1 | n yrs. last birthday) IF U | NOER 1 YEAR IF UNDER 24 HRS. | February (| 8. BIRTHE | PLACE (State or Foreign | | | | | |
| | ZZ0-18-5853 | 1 - M 2 XF 6 | YRS. MONT | HS DAYS HOURS MIN. | May 241 | 9Z6 Country | MD. | | | | | |
| æ | 9a. FACILITY NAME (If not institution, give st | reet and number) | 9b. | CITY, TOWN OR LOCATION OF D | | c. COUNTY OF DE | утн | | | | | |
| CTO | RESIDENCE OF DECEDENT | rospital | | paltimory | 2 | 10/1 | 4 | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | 11/2 | | | | | | | | | | |
| | 10e. STREET AND NUMBER | 101. ZIP CODE 109. CITIZEN OF WHAT COUN | | | | | | | | | | |
| FUNERAL | 913 South Linwood Avenue ZIZZY U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No - 14. RACE - American Indian. | | | | | | | | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DA | 2 NO | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 WO Specify Cuban | en, Puerto Ricen, etc.) | No — 14. RACE Black, Specifi | , White, etc. | | | | | |
| D BY | 3 Widowed 4 Divorced | | | 1 4 | DHITE | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | (Give kind of work of life. Do NOT use retir | lone during most of working | 16b. KIND OF BUSIN | ESS/INDUSTRY | | | | | | |
| MPL | 8 | contract (1-4 of 5 4) | Cool | Y | RESTU | PAPT | | | | | | |
| | 17. FATNER'S NAME (First, Middle, Lest) | VCK HAR | 7 | 18. MOTHER'S N. | AME (First, Middle, Meiden Sur | name) | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type@rint) | CATIAR | 7 | RESS (Street and Number or Rural | Route Number, City or Town, S | State, Zip Code) | | | | | | |
| 2 | DARLENE SMOO | T ROBERS | 5041 | MENDLIA | RD. JOPA | OM MO | . 21085 | | | | | |
| | 20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | | PLACE AND DATE OF DIS elery, cremator of other p | | 2-10-96 BA | TION — City or Toy | wn, State | | | | | |
| | 21. SIGNATURE OF CUNERAL SERVICE LIC | ANSEE A D | 1 A | 22. NAME AND ADDRESS OF F | ACILITY A P2 G | 11/120 | 24157 | | | | | |
| | * Thomas | 1. Skar | le h. | SKARDA F. | H. BALTI | MD. | 21224 | | | | | |
| | 23. PART i. Enter the disesses, or shock, or heart fellure. | complications that caused List only one cause on e | the death. Do not e | nter the mode of dying, su | ch as cardiac or respirat | ory strest, | Approximats interval Between | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | T. | • | | | | Onset and Daeth | | | | | |
| | disease or condition resulting in death) s. TSChemic Bouve Due to (or as a consequence of): | | | | | | | | | | | |
| NO | Sequentially list conditions, | b | COMPEQUENCE OF | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| TIFIC | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| CER | resulting in death) LAST | d | | | | | | | | | | |
| AL | PART II. Other significent condition | _ | | | Part i. 24s. WAS AN AU PERFORME | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | | |
| PHYSICIAN: MEDIC | \ \ \ \ \ | 1 | Disease | 2 | 1 TES 2 | • | OF DEATH? | | | | | |
| M | DID TOBACCO USE CONTI | | | □ NO □ UNCERTA | IN 🗆 | | 1 TES 2 NO | | | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH (C | heck only one) | - 1 | | | | | | | |
| YSI | 1 TES 2 NO | 1 Sinpetient 2 - ER/Outp | etlent 3 DOA 4 | Nursing Nome 5 - Residence | | | | | | | | |
| / PH | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DEŞCRIBE NOW INJ | JRY OCCURED | | | | | | |
| D BY | 2 Accident investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, stc. (Spec | — At home, ferm, street | , factory, office | 281. LOCATION (Street and City or Town, State) | Number or Rural R | loute Number, | | | | | |
| COMPLETED | 4 Nomicide datermined | | | | | | | | | | | |
| MPL | (Critick Drilly | | | the time, data and place, and du my opinion, death occured at th | | | and manner as stated. | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | 29c. LICENSE N | | 29d. DATE SIGNED | | | | | | |
|) BE | 1 that 1 | CITT | wo | M5 | | Fabru | | | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATN (ITEM 27) (Type, Prin | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | / 32. REGISTRAR'S SIGN | ATURE | | | | | | | | | |
| | FEB1 3 1996 | ali Davolen Re | Sall | | | | | | | | | |
| | | | | | | | DMMN 18 Day 1/80 | | | | | |



TO THE HOSP IN CHATRINOUNG PHYSICIAN: The law requires that the death certificate be executed within an incompletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DWISION OF VITAL RECORDS, P.O. BOX 68760,

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | | | | EALTH AND | MEN | TAL HYGIEN | E | | |
|-------------------------------------|-------------|--|--|--------------------|---------------|--------------|-------------|---|---------|---|------------------|--------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) | - | | | - | | | | ATE OF DEATH | | VEAD | 3. TIME OF DEATH |
| | | William Wathen | | | | | | | F | ёb. 12 | , 19 | 96 ⁸ | 11:08 ам |
| | | 215-12-5742 | M 2 F | in yrs. last 76 | YRS. | IF UNDER | DAYS | IF UNDER 24 HRS. HOURS MIN. | Se | onth, Day, 164) | 1919 | 8. BIRTI Punt Mai | PLACE (State or Foreign ryland |
| | P P | 98. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center Towson Baltimore RESIDENCE OF DECEDENT | | | | | | | | | | | |
| | DIRECTOR | 10s, STATE 10b, COUNTY | | | 10c. CITY | , TOWN O | R LOCAT | ION | | | | | 10d. INSIDE CITY |
| | | Maryland N/A | | | Ва | 1tim | | ZIP CODE | | | L 40 - 01T | | LIMITS? 12 YES 2 NO WHAT COUNTRY? |
| | ERA | 731 St. Johns Road | i | | | | 100 | 21210 | | | | S.A. | |
| | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | . WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 XN | MED O | 1 | yes, spe | ENDENT OF HISPAR ecity Guben, Mexica 2 NO Specifi | n, Pue | | or No- | 14. RACI Blac Spec | E — American Indian, k, White, atc. |
| | COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 + years 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector | | | | | | | | | | ity | partment |
| once. | ∑ | 17. FATHER'S NAME (First, Middle, Last) | years | Jerry | pect | OL | | 18. MOTHER'S NA | ME (Fi | st, Middle, Maiden | | | |
| te p | BE | William | | Lew | | | | Mabel | Α. | | | Nort | h |
| e notifie | 2 | 199. INFORMANT'S NAME (Type/Print) Donna H. Lewis (wife 731 St. Johns Road Baltimore, MD 21210 | | | | | | | | | | | |
| must b | | 20e-METHOD OF DISPOSITION 1 | from State gern | | ND DATE O | | | rne of Feb | 1 | | cation — timo | | Maryland |
| f examiner must be notified at once | | 21. SIGNATURE OF FUNERAL SERVICE LICENT | seph Bos | el | | 6 | 500 | ell-Wied York Rd | . B | altimore | e, M | 212 | 212 |
| atic event, the medical | | 23. PART I. Enter the diseases, or com- ahock, or heart fallure. Liet IMMEDIATE CAUSE (Finel disease or condition resulting in death) | plicefrone that cause on an only one cause on an only one cause on an one of the cause of the ca | ach Ilna. | | | | | | | | reat, | Approximata interval Between Onset and Daeth |
| or other traum | RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | | | |
| | AL CEI | PART II. Other aignificant conditions of | ontributing to death b | ut not re | eulting i | the un | derivino | ceuse given in | Part I | . 24s. WAS AN | AHTOPSY | 246 | WERE AUTOPSY FINDINGS |
| shows any | N: MEDICA | DID TOBACCO USE CO | | | | | | | _ | PERFOR | MED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 5 ~ . | SICIA | | OSPITAL: | | | OTHER | | ACE OF DEATH (Ch | eck onl | y one) | | | |
| 6 | HYS | 1 VES 2 NO 1 | XInpatient 2 ER/Outp | atient 3 | DOA 28b, TIME | 4 🗌 Nurs | | 5 Residence | | | | | |
| W. | BY P | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | | INJU | M | 1 🗌 Y | RK? ES 2 NO | 280. | DEŞCRIBE HOW II | NJURY OC | CURED | |
| 28 82 | ETED | 3 Suicide 8 Could not be 4 Homicide detarmined | 28s. PLACE OF INJURY building, etc. (Spec | — At hon | ne, farm, s | lreet, facto | ory, office | | 281. | OCATION (Street a City or Town, State) | and Numbe | r or Runal I | Route Number, |
| Ž | COMPL | 298. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: 0 | | | | | | | | | | | s) and manner as stated. |
| PORT | W | 29b. SIGNATURE AND TITLE OF CERTIFIER | 1160 C | bes | , | | | 29c. LICENSE NUI | MBER | 49 | 29d. DAT | E SIGNED | (Month, Day, Year) |
| | 2 | 30. NAME AND ADDRESS OF PERSON WHO CO A. Hamid Ghiladi | .M.D. 76 | 500 | | | r. | Towso | n. | MD 212 | | | |
| | | FEB 1 3 1996 Jalia | 3 AEGILIEVE AGA | Sur! | | | | | , | | | | |

A. Same

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| PHOTHER FINAL THE law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | Interface American be sensioned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmit Pages 1.2 selected | and the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | and 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|--|--|---|--|
| TO THE HOSPITAL CHAUTENDING PY | TO THE FLANSON DIPRESTOR: After th | be filed within 72 hours after death w | IMPORTAKE, IL jamin 28 is marke | |

| | | | | | | | | | | | | 96 | 03571 |
|--------------------|--|----------------------------|------------------------------|--------------------|--|---------------|------------|---------------|-----------|--|---------------------|----------------|--|
| | FOR STATE REGISTRAR | | STATE OF I | | / DEPAI | | | | | MENTAL HYGIE | | | |
| | 1. DECEDENT'S NAME (First, | , Middle, Last) | | | | IOAII | - 01 | DEA | | REG. N | | | 3. TIME OF DEATH |
| | JUDITH | | | LICHT | | | | | | FEBRUARY 6,1996 12: | | | 12:50pm |
| | 4. SOCIAL SECURITY NUMBER 191 32 5708 | | 5. SEX | 6. AGE (In yrs. Is | | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | | IPLACE (State or Foreign |
| | | | 1 🗌 M 2 💢 F | 36 | YRS. | | | | | May 30 | 1939 | Per | nsylvania |
| Œ | THE JOHN H | T T 0 1 | | | | OR LOCATI | | | | INTY OF D | 7.27 | | |
| 20 | RESIDENCE OF DEC | EDENT | | I I AL. | BALTIMORE CITY Baltimor | | | | | | nore | | |
| DIRECTOR | Maryland | Mont | gomery | | | lvei | | | ~ | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | MOTI | gomery | | 1 21 | Tvei | | E. ZIP COD | | | | | XXYES 2 NO |
| FUNERAL | 506 Sisson | Stre | eet | | | | 10 | 209 | T-1 | | 10g. CIT | USZ | YHAT COUNTRY? |
| N | 11. MARITAL STATUS | - | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. A | RMED | 13. | WAS DEC | _ | | NIC ORIGIN? (Specify | es or No | | E — American Indian, |
| BY F | 1 Never Married 2 3 | Married | FORCES? 1 | | MO | | If yes, sp | | n, Mexica | in, Puerto Rican, stc.) | | Black Speci | c, White, etc. |
| | | EDENT'S EDU | CATION | | | | | | | | | | "White |
| ETE | (Specify only Elementary/Secondary (0 | highest grade | completed) College (1-4 or 5 | | ECEDENT'S Give kind of e. Do NOT u | work done | during mo | ost of worldi | ng | 16b. KIND OF E | USINESS/IN | DUSTRY | |
| COMPLETED | | | 5+ | | choo | 1 Te | each | ner | | Princ | e Ge | orge | es County |
| | 17. FATHER'S NAME (First, MI | | | | | | | | | ME (First, Middle, Meld | n Surname) | | |
| BE | Richard Morganstern Anita Freund 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS / Street and Mumber of Burel Burel Burel Burel Street Top Code) | | | | | | | | | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Licht same as item #10a-f | | | | | | | | | | | | |
| | 20g METHOD OF DISPOSITI | ION | | 20b. PLACE | | | | | 104 | | OCATION — | City or To | wn. Stata |
| | 4 □ Donation 5 □ Other | (Specify) | | Kno. | ematory or o | od I | Park | Cer | m | 2/7 Di | 3~0 | 500 | Morr Voul |
| | 21. SIGNATURE OF FUNERAL | L BENVICE LIC | ENBEE | | | 22. | NAME AI | Pe | arso | on Funer | al H | omes | New LULK |
| | - Coms | WE | Jul | an - | | j F | all | s C | hur | ch, Virg | inia | 2 | 22046 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fellure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between |
| | iMMEDIATE CAUSE (Fin | al | 11. | | , , | | | | | | | | Onset and Death |
| | resulting in death) | → | DUE TO | (OR AS A CONSE | OUENCE O | la-y+- fi: | one | has | 10- | | | | 12 hour |
| z | | | mil | tink | 01.1 | ctet | 0 | an i | (| totion | | | 1 month |
| FICATION | Sequentially list condition if any, leading to immediate | liate | DUE TO | OR AS A CONSE | OUENCE O | f): | , 0 | Jan . | au. | - Corn | e pur | | 111111111111 |
| | CAUSE (Disease or Injur | | be ben | (OR AS A CONSE | CHENCE O | y 7 | ho | nop | lon | tetion | | | 4 month |
| | thet initiated events resulting in death) LAST | т [| acut | 1-17 | do | ,- | | 0.2 | / / | onie | | | 7 mate |
| CER | PART II. Other eignificar | nt condition | a contribution to | | / | | | | | | | | |
| PHYSICIAN: MEDICAL | re La | L | , , | on bo | | | | | iven in | | N AUTOPSY PRMED? | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Œ | | 7 | | are ou c | 7 | fre | ne u | • | | 1 🗆 YES | 2 NO | | OF DEATH? |
| Ž. | DID TOBACCO US | SE CONTR | RIBUTE TO CA | USE OF DEA | ATH YE | S 🗆 I | NO Z | UNC | ERTAIN | <u>-</u> | | | 1 VES 2 NO |
| CIA | 25. WAS CASE REFERRED TO EXAMINER? | | HQSPITAL: | | CE OF DEA | | | | | | | | |
| YSI | 1 TYES 2 NO | | 1 Inpatient 2 | | | _ | | e 5 🗆 Re | sidence | 8 Other (Specify) | | | |
| | 27. MANNER OF DEATH 1 Netural S T | Pending | 28a. DATE OF (Month, D | | 28b. TIM | IE OF FURY | - Contract | RK? | | 28d. DESCRIBE HOW | INJURY OC | CURED | |
| ВУ | 3 Suiside | nvestigation | 28e. PLACE O | F INJURY — At h | ome, farm. | etreet, fect | | /ES 2 [| NO | 281. LOCATION (Stree | and Number | or Rural D | inute Mumber |
| TED | | Could not be latermined | building, | etc. (Specify) | | 24, 1800 | .,, 2/1101 | | | City or Town, Star | e) | or mores M | oud minum, |
| COMPLETE | 29a. CERTIFIER (Check only | FYING PHYSIC | CIAN: To the best of | my knowledge, d | eath occum | ed at the ti | me, data | and place, | and dua | to the cause(a) and m | anner as stat | led. | |
| 8 | | | | | | | | | | | | | and manner as stated, |
| BE C | 29b. SIGNATURE AND TITLE | OF CENTURIER | 11 | | ^ | | | 29c. LICE | NSE NUN | IBER | 29d. DAT | E SIGNEO | (Month, Day, Year) |
| 0 | Allan | | Hihm | 7 m | 0 | | | 12 | 2200 |) | 1 /re | bru | my 6 1996 |

| | | the second secon | re-in occurred at the talle, date and place, er | d due to the cedse(a) and manner as a |
|-------------------------------------|---|--|---|---------------------------------------|
| b. SIGNATURE AND TITLE OF CENTIFIER | / | | 29c. LICENSE NUMBER | 29d. DATE SIGNEO (Month, Day, Year) |

Johns

MD FEB 1 3 1996

32. REGISTRAR'S SIGNATUR

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30. NAME AND ADDRESS OF PERSON WHO

S1. DATE FILED (Month, Day, Year)
FEB 1 3 1996

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| HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writim 24 hours after death. Page 6 may be retained by the | age | | fANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at it |
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ITEM: 1. PER F.H. FILM G-732 2/13/96 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Feb 904 996 3. TIME OF DEATH
3:00 am WILLIAM YEAR MESSENGER ALBERT 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS HOURE 1 X M 2 - F 67 220-20-4521 September 21 Maryland 9e. FACILITY NAME (If not institution, give street end number 9c. COUNTY OF DEATH
Baltimore 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland Saint Joseph Medical Center DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1100 Armistead Way 21205 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TYES 2 NO Specify BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10 Heavy Equipment Operator Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) William <u>Messenger</u> Myrtle (Unknown) BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Eleanor M. Messenger 1100 Armistead Way Baltimore, Maryland, 21205 20e. METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Holly Hill Cemetery Donation 5 Other (Specify) 2/12/96 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. Mark T. Zouspra 5305 Harford Road Baltimore, Md. 21214 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart fellure. List only one cause on each line. Interval Batween Onset and Death
7 DAYS IMMEDIATE CAUSE (Final CEREBROVASCULAR ACCIDENT disease or condition resulting in death) DIABETES MELLITUS 20 YEARS CERTIFICATION Sequentially list conditions, HYPERTENSION ARTERIOSCLEROTIC CARDIOVASCULAR if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initieted events DISEASE 20 YEARS resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED MAILABLE PRIOR TO COMPLETION OF CAUSE PERIPHERAL VASCULAR DISEASE 1 TYES 2 PMO OF DEATH? 1 VES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 © inpatient 2 □ ER/Outpatient 3 □ DOA EXAMINER? OTHER 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rurel Route Number, City or Town, State) 3 Sulcide 8 Could not be COMPLETED 4 Homicide determined t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner es stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner se stated 29b. SIGRATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, BE D 24710 de -

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PEATH (ITEM 27) (Type, Print)
ARMANDO A. REAL, MD ST. JOSEPH MEDICAL CENTER 7620 YORK ROAD TOWSON, MD 21204

37 REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

| JE-JIGSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | ID THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages | Se filed_within \overline{z} hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal. | MPOGRANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|--|--|---|--|
| TO THE HOS | THE FUN | be filed with | MPORTAN | |

31. DATE FILED (Month, Day, Year)
FFB1 31996

| 1. DECEDENT'S NAME (First Middin, Last) THOMAS MARTIN MALONEY, SR. 4. SOCIAL SECURITY NUMBER 2. 17 - 03 - 2748 1. SEX 2. AGE (in yrs. last brinday) 2. 17 - 03 - 2748 3. TIME OF DEATH MONTHS DAY'S HOURS MIN. (Month, Day's hear) 2. DAYE of DEATH MONTHS DAY'S HOURS MIN. (Month, Day's hear) Dec. 30, 17 Maryland 8. BINTIFFLACE (State or Fo. Country) Dec. 30, 17 Maryland 8. BOLITY, TOWN OR LOCATION OF DEATH MORTHS DAY'S HOURS MIN. MONTHS DAY'S HOURS MIN. Dec. 30, 17 Maryland 8. COUNTY OF DEATH MORTHS DAY'S HOURS MIN. Dec. 30, 17 Maryland 8. COUNTY OF DEATH MORTHS DAY'S HOURS MIN. Dec. 30, 17 Maryland 8. COUNTY OF DEATH MORTHS DAY'S HOURS MIN. Dec. 30, 17 Maryland 8. COUNTY OF DEATH MORTHS DAY'S HOURS MIN. Dec. 30, 17 Maryland 8. COUNTY OF DEATH MARYland Baltimore 100. STATE MORTHS DAY'S HOURS MIN. Dec. 30, 17 Maryland 100. STATE MORTHS DAY'S HOURS MIN. Dec. 30, 17 Maryland 100. INSIDE CITY LIMITS? 1 DECEDENT 11. MARTAL STATUS 11. MARTAL STATUS 11. MARTAL STATUS 11. MARTAL STATUS 11. MARTAL STATUS 12. MAS DECEDENT EVER IN U.S. ARMED FORCES? 1 DYES 2 DON 16 YES, QIVE WAR OR DATES. 11. MARTAL STATUS 11. MARTAL STATUS 12. MAS DECEDENT'S EDUCATION (Give kind of work done during most of working line Do KOT use reliefed.) 13. MAS DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working line Do KOT use reliefed.) 14. MARTAL STATUS 15. DECEDENT'S EDUCATION (Give kind of work done during most of working line Do KOT use reliefed.) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working line Do KOT use reliefed.) 16. MOTHER'S NAME (First, Middie, Maiden Summers) 17. FATHER'S NAME (First, Middie, Maiden Summers) 18. MOTHER'S NAME (First, Middie, Maiden Summers) 19. MAS DECEDENT'S NAME (F | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|
| THOMAS MARTIN MALONEY, SR. 4. SOCIAL SECURITY NUMBER 2.17-03-2748 1.2 M 2 F 78 1.3 M 2 F 78 1.4 M 2 F 78 1.5 SEX 3. AGE (in yrs. lest birthday) 4. SOCIAL SECURITY NAME (if not institution, give street and number) 5. SEX 4. SOCIAL SECURITY NAME (if not institution, give street and number) 5. SEX 5. AGE (in yrs. lest birthday) 7. F 78 7. F 78 7. F 78 7. F 10 MONTHS 1. Dec. 30, 17 Maryland 9. COUNTY OF DEATH 1. Maryland 9. COUNTY OF DEATH 1. Maryland 9. COUNTY OF DEATH 1. Maryland 9. COUNTY OF DEATH 1. Maryland 1. Ma | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 217-03-2748 1 | | | | | | | | | | |
| 217-03-2748 1 | | | | | | | | | | |
| 217-03-2748 1 X M 2 F 78 98. FACILITY NAME (If not institution, give street and number) 98. CTY, TOWN OR LOCATION OF DEATH Mercy Hospital RESIDENCE OF DECEDENT 108. STATE 108. COUNTY 109. CTY, TOWN OR LOCATION Dundalk 109. CTY, TOWN OR LOCATION Dundalk 109. CTIZEN OF WHAT COUNTRY? 3411 McShaneway 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? I YES 2 YOU If yes a poselfy Cuban, Mexican, Puarto Ricen, etc.) 13. Widowed 4 Divorced 15. Decedent State White a poselfy: White Specify: White Specify: White Specify: White Supervisor 16. KIND OF BUSINESS/INDUSTRY American Smelting & Supervisor 17. FATHER'S NAME (First, Middle, Last) John Maloney 199. MALLING ADDRESS (Street and Number or Rural Foure Number, City or Town, State, Zip Code) | | | | | | | | | | |
| Baltimore N/A | | | | | | | | | | |
| 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2X | | | | | | | | | | |
| Maryland Baltimore Dundalk 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1 | | | | | | | | | | |
| 3411 McShaneway 21222 United State 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 | | | | | | | | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 2 NO If Yes 2 NO IF YES, GIVE WAR OR DATESX 13. Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refined.) 7 Years 17. FATHER'S NAME (First, Middle, Last) John Maloney 19. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 TOO If YES 2 TOO IF YES 2 TOO If YES 2 TOO IN YES 2 TOO | | | | | | | | | | |
| (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7 years 17. FATHER'S NAME (First, Middle, Last) John Maloney 19a. INFORMANT'S NAME (Type/Print) (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use refired.) American Smelting & Refinery 16. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Drumgoole 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7 Years 17. FATHER'S NAME (First, Middle, Last) John Maloney 19a. INFORMANT'S NAME (Type/Print) (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) American Smelting & Refinery 16. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Drumgoole 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 7 years Supervisor Refinery 17. FATHER'S NAME (First, Middle, Last) John Maloney Irene Drumgoole 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| John Maloney Irene Drumgoole . 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| | | | | | | | | | | |
| 198. INT OTHERAT 3 CHARC (Typer Int) | | | | | | | | | | |
| | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22 NAME AND ADDRESS OF FACILITY HOME Of Dundalk, Inc. | | | | | | | | | | |
| 7922 Wise Avenue Dundalk, Maryland 2122 | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in desth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? ANALABLE PRIOR COMPLETION OF CO | | | | | | | | | | |
| OF DEATH? | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF (OF DEATH') 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OF DEATH' 26. PLACE OF DEATH (Check only one) EXAMINER? 1 I Inpetiant 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 8 X Other (Specify) HOSPICE AT MET 27. MANNER OF DEATH 28. DATE OF INJURY 2 286. DISCRIBE HOW INJURY OCCURED INJURY WORK? | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | |
| 1 See Date OF INJURY 286 DATE OF INJURY 286 DATE OF INJURY 286 DATE OF INJURY 286 DATE OF INJURY 286 DATE OF INJURY 286 DATE OF INJURY AT 286 DESCRIPTION OF INJU | | | | | | | | | | |
| (Month, Day, Year) INJURY WORK? | | | | | | | | | | |
| 2 Accident Investigation | | | | | | | | | | |
| 3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, atreet, factory, office City or Nown, State) 281. LOCATION (Street and Number or Rural Route Number, City or Nown, State) | | | | | | | | | | |
| 29a. CERTIFIER (Check only Control of the cause(s) and manner as stated. | | | | | | | | | | |
| (Check only one) 2 MEDICAL EXAMINER: On the beats of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | |
| 270980 | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 58/0 BELAIR RD. FERNANDO J. FERRO, MD BARTO, MD 21206 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 432. REGISTRAPS SIGNATURE | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Jerible 2/13/96 + + State of Maryland / Department of Health and Mental Hygiene 96 2/13/96 t.t

| | | | | | | | Ce | rtificate | of De | ath | | Reg. No. | | | |
|------|--|---------------------|---|---|--|---------------------------|-------------------------------------|--------------------------------|--------------|---|-------------------------------------|------------------------|---------------------|--------------------------|--|
| | | | 1. Decedent'a Name (First, Mid | dla, Last) | | - | | | | | 2. Deta of D | eath | | .059 | 3. Time of Death |
| | Physic | | William | n | | MC | Gainey | | | | Month Feb. | 5 Day | 1996 | Yaar | 4:45pm |
| | /Medi Exami | | 4a. Facility Name (If not instituti | | treet and nui | | outhey | | 4b. Ci | ty, Town, or L | ocation of Dea | | | of Death | 4.43911 |
| | LAGIIII | iiei | | | | | | | | | | 130 | | | |
| - | | | Franklin Squ 5. Social Security Number | 6. Sex | | | rs. last birthday | If Under 1 | | Rossv: Inder 24 Hra. | | ieth | Dd. | ltim | |
| | Funeral Director | | 219–22–4912 Usuel Residence of Decedent | | M 2□F | r. Age (m) | 67 Yrs. | | | ours Min. | 8. Data of B (Month, D July 5 | by, Year) | 28 | | laca <i>(Steta or Foreign</i> try) Yland |
| | and *= | | 10a. Stata 10b. Count | ty | | 10c. | City, Town or L | ocation | | | | | | 1. | 0d. Inside City Limits |
| | ith with the Marylan 23a or 28a-f show | ctor | Md. Ba | altim | ore | | | | Essex | | | | | | 1 ☐ Yas 3☐ No |
| | 5 th | ire | 10e. Street and Number | | | | | 10f. Zip C | ode | | | 10g. Citi: | zen of V | Vhat Coun | itry? |
| | h wi | 100 | 711 Maryland | ave l | | | | | 21 | 221 | | | US | SA | |
| | or Items | by Funeral Director | 11. Merital Stetus 1 Never Merried 2 類 Me 3 Widowed 4 Divorce | rried | 2. Was Dece Armed Fo 1 Yas If Yes, Gh Yaer or D | rcas? ≱E No ⁄e | U,S. 13. | Wes Decedar If Yaa, specify | y Cuban, Me | ic Origin? (Spexican, Puerto | pecify Yes or N Rican, atc.) | | | k, White, | an Indian, etc. ite |
| | n 72 hours natural', | Completed | 15. Decede (Specify only high | nt's Educ | ation | | 16e. Dece | dent's Usuel (| Occupation | most of work | cina | 16b. Kir | nd of Bu | siness/Inc | dustry |
| | 4 . 5 | pje | Elemantary/Secondary (0-12) | | College (1 | -4or 5+) | life. | DO NOT use | retired) | , most of work | ung | | | | |
| | s 1 and 2 should be filed within I heelth and Mental Hygiene. tem 27 is marked other than other traumatic event, the M | Son | 10th | | | | Tr | uckina | | | | | r | ı/a | |
| | a filed If Hygi other | Be | 17. Fathar's Name (First, Middle | a, Last) | | | | | | Mother's Nam | e (First, Middle | e, Maiden | | | |
| | ould be i Mental I arked of atic eve | ToE | Hugh Patrio | k Mo | Gaine | 7 | | | | Rose 1 | May Loh | nman | | | |
| | 2 should and Men is marke | - | 19e. Informant's Neme/Reletion | | | <u> </u> | 19b. Maill | no Address / | Street and N | | ral Routa Numi | - | r Town | State Zin | Code |
| | 2 2 2 2 | | Dorothy McGair | | -, | | | | | | | | | | 0000) |
| | is 1 and 2 if Heelth Item 27 I | | 20e. Method of Disposition | 201 | . Plece of Dispo | | | e. Dal | | imore Md. 21221 Date 20c. Location - City or Town, State | | | | | |
| | thent of the state | | 1 Donetion 5 □Other | 2 /0 | | | | | | | | | | | |
| | Industria. | | 21. Signeture of Funerei Service | | 2/9, | /90 | | ватт | imor | e Md. | | | | | |
| | Depa Impo any ir | | D. | a Elouitoo | 10 | | 1/1/ | Connol | | - | Home of | Fee | 037 | | |
| | | | 23e. Part1. Enter the disease, shock, or heart failure. Lis | My | (05 | me | lly | 300 Ma | CO AV | o. Ral | timore | Md | 2122 | 21 | |
| | | | 23e. Part1. Enter the disease, of shock, or heart failure. Lis | or complic | ations that of | sused the de ach line. | eath. Do not en | er the mode | of dylng, su | ch es cardiac | or raspiratory | arrest, | ~ I ~ Z | | Approximata Interval Between |
| | Physician /Medical Examiner | Н | Immediate Cause (Final diaaasa or condition resulting in deeth) | | | | / | | | | | | | 1 | Onset end Death |
| | | | resulting at Gootil) | | | Due to | (or es e conse | quenca of): | | 0 | | | | | |
| | D # | i | | b. Mobble Aut Mysiardia Inforce Due to (or es a consequenca of): Due to (or es a consequence of): | | | | | | | | | ch | 5 | |
| | oute Inans | Examiner | Sequentially list conditions, | | - | Due to | (or es s conse | quence of): | 0 | | | - | | 1 | |
| | e Para | | Sequentially list conditions, if any, laeding to immadiate cause. Enter Undarlying Cause (Disease or Injury | | | | | | | | | | | 1 | |
| | o Zick | edicai | | C. | | Due to | (or aa a consec | uence of): | | | | | | - | |
| - | eath certificate be executed attending physician and for use as the burial-transit | Medi | resulting in death) Lest | L | | D00 t0 | (or as a consec | derica or). | | | | | | | |
| | death c e attend d for us | Physician | Pert II. Other significant condit | Inne conti | ributing to de | ath but not r | esulting in the u | nderlylna cau | se aiven in | Part I | 23h Did | tobacco | uee cor | tribute to | the cause of death? |
| | The law requires that the death ate has been signed by the atter page 2 should be detached for a | Phys | NIOD. | m, | olse | Tuela | re puly | unacy | 5 de | rear | | Yes 2 | | | bebly 4 Unknow |
| | signed be de | d by | 14.1 | north | hem | <u>`</u> | 1 (00) | ulled | | _ | 240 140 | s en sutop | | 24h Wa | ere sutopsy findings |
| | v require been si should | Completed | 1-7/ | 0 0- | | | (40 /4 | | | | perf | ormed? | sy / | ava | aliable prior to |
| | has t | ğ | | | | | | | | | | | | of c | death? |
| ě | The Late ha | 5 | | | | | | | | | 10 | Yaa 20 | No | 1 🗆 | Yas 2 No |
| | | Be | 25. Wes case refarred to medic | ai | | - | 1-11 | | 28. | Plece of Deet | th (Check only | one) | | | |
| | Physician: this certific rai director, | 0 | examiner? 1 ☐ Yes 2 ☑ No | Ho | spitel: | npatient 2 | LEPER/Outpatier | 1 31000A | Other | | ma 52 Hes | | ПОнь | or (Specify | 4) |
| | E E E | Ë | 27. Menner of Deeth | | 28e. Dete | | 28b. Time o | | | | 28d. Describe | | | | " |
| | After funer | 흕 | 27. Menner of Deeth 28e. Dete of Injury 28b. Time of Injury st (Month, Day Year) 28b. Time of Injury st Work? | | | | | | | | | | , | | |
| 0 84 | or Attending after deeth. Director: After d in by the fune | Certification: | 3 Suicide 6 Could | - | | | home, ferm, str | | | | | | | er or Rura | l Route Number, |
| - | P D P P P P P P P P P P P P P P P P P P | Cer | | | Dundir | ng, etc. (Spe | uny) | | | | Only of To | wn, Stste) | | | |
| | To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b | edicai | 29e. Certifier (Check only one) 1 ☐ Certifyi 2 ☐ Medica | ng Physic I Examine | clan: To the er: On the ba snd menn | sis of exami | nowledge, deetl netion snd/or in | occurred at vestigetion, in | the time, de | te end place, , deeth occur | and dua to the red et the time | cause(s) , dete end | end mai pisce, s | nnar as st ind due to | ated. the ceuse(s) |
| 1 | Vithir omp | Me | 29b. Signature and titia of cartific | 9r | | | | 29c. L | icense num | ber | | 29d. Deta | a signed | (Month, I | Day, Year) |
| | ->-0 | | Igrorge N. | 16 | Ma | MI |) | / | 0161 | 189 | | 2- | 6 | 199 | |
| | | | Lake. | , 2 | | | | | / | -/ | | | | 1/ | - |
| | | | | | | | | | | | | | | | |

State

GEOR GE N. KARKAR

31. Dete flied (Month, Dey, Year)

32. Registrar's

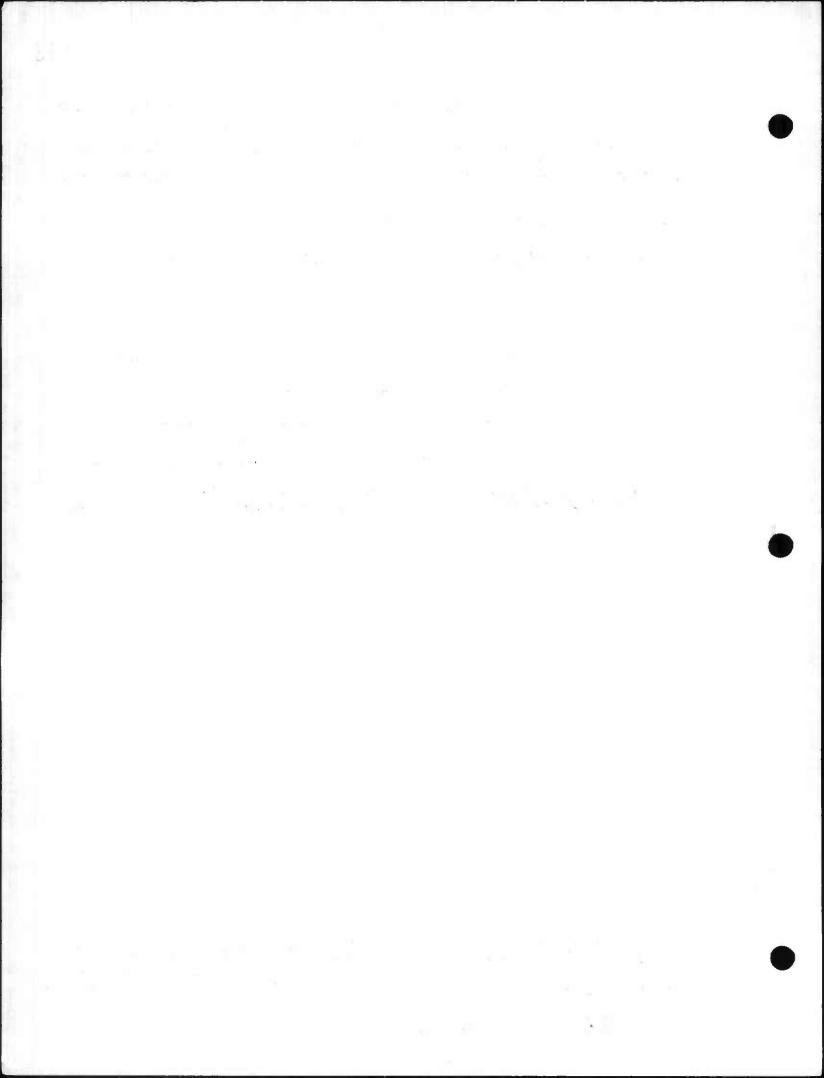
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 96

| | | | | | | Cer | tificate o | f Death | | F | Reg. Nc | | | |
|------------|---|----------------------|--|---|---------------------------------|-------------------------------------|--|------------------------------------|--------------------------|---|----------------------------------|---------------------------------------|--|---------------------------|
| | Physic /Med | | 1. Decedent's Nama (First, Middla, L WILLIAM | J. | McDON | NALD | | | 13 | 2. Data of Dea | | 6 ^{Yaar} | 3. Time 2AN | of Death |
| | Exami | | 4a. Facility Nama (If not institution, grant ANNAPOLIS NURS) 5. Social Sacurity Number 6. | SING AND RE | HABIL. | | ON CTR. | ANNAP | OLIS | cation of Death | 4c. County ANNE | ARUND | | a or Foreign |
| 1 | Funeral Director | | 136-12-2260 Usual Rasidanca of Decedant | M 20 F 7 | 4 | Yrs. | Months Day | | Min. | 8. Data of Birth (Month, Day JAN . 20 | 7, Year) 0, 1922 | VEW J | ERSE | a <i>or Foraig</i> n Y |
| | the Maryier 28a-f show | Director | MD . 10b. County ANNE ARU 10e. Street and Number | INDEL | 10c. City, T ED(| GEWATI | | | | | 100 011 | | 1□ Ya | City Limits |
| | th with | al Dir | 1426 REHLING | STREET | | | | 037 | | | 10g. Citizan of USA | what Coun | try 7 | |
| 020 | be filed within 72 hours efter death with the Maryland let Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be notified at | by Funeral | 11. Marital Stafus 1 Nevar Married 2 Married 3 Widowad 4 Divorced | 12. Was Dacedant E Armed Forcas? 1/ Yas 2 N If Yas, Giva Yaar or Datas: | | | Vas Decedant of Yas, specify C | | gin? (Spa I, Puarto I | cify Yas or No- Rican, atc.) | | ce - Amaric ck, Whifa, i y: WHI | atc. | |
| 21215-0020 | ges 1 and 2 should be filed within 72 hours to of Health and Mentel Lygiene. If Ifem 27 is marked other than "natural", or other traumatic event, the Medical Exi- | Completed by | 15. Decedant's E (Specify only highast gi Elamentary/Secondary (0-12) 12 | ducation ada complated) Collega (1-4or 5 | | 6a. Deced (Giva I life. D | ent's Usual Occ kind of work dor OO NOT usa reti INER | rupation na during mos ired) | t of workin | ng | 16b. Kind of B | | lustry | |
| Maryland | 2 should be filed within and Mentel Hygiene. Is marked other than reumatic event, the Me | To Be C | 17. Fathar's Nama (First, Middla, Las WILLIAM | J. | McI | OONALI | D | 18. Mothe ROSI | | (First, Middla, | Maidan Sumar SPRING | | | |
| | 1 and 2 should Health and Men am 27 is marke ther traumetic | | 19a. Informant's Name/Raietionship WILLIAM C. McDONA | | | | g Address (Stre LEE WAY | | | Routa Numbe R, MARYI | | | Code) | |
| Baltimore, | permit. Pages 1 and Department of Health Important: If fiem 27 any Injury or other to once. | | 20a. Mythod of Disposition 1 🗓 Burial 2 🗆 Cramation 3 [4 🗆 Donation 5 🗀 Othar (Special Content of the Co | □Ramoval from Stata | cem | atary, cram | sition (Nama of natory or other p VETERAN | | FE | Data B 13,96 | 20c. Location 5 CROWN | | | • |
| Balt | permit. Departm Importa any Inju | | 21. Signature of Feneral Service Lice | nsee All | | | Nama and Ado ARDESTY 2 RIDGE | | | | | ND 21 | 401 | |
| Box 68760, | nding use | lan/Medical Examiner | Cause (Diseasa or Injury that Initiated events rasulting in death) Lasf Dua fo (or as a consequence of): d. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco | | | | | | | | | | Approxim Interval B Onset and | atween d Death Pulls |
| P.O. | that the de ed by the s detached i | | Part ff. Other significant conditions | contributing to death bu | t nof rasultin | g In tha un | derlying causa | givan In Part i | | | | ontributa to 3 ☐ Prob | | of death? |
| Records, | a lew requires that hes been signed b je 2 should be dete | Completed by | | | | | | | | 24a. Was a perfor | an autopsy med? | ava | ere autops allabia prio mplation o death? | or to |
| VITAI H | ₽ ag | 0 | 25. Wes casa rafarred to medical | <u> </u> | | | | 26 Place | of Death | 1 □ Y | | 10 | Yas 2 | □ No |
| on of | nding Physician: ath. The After this certific funeral director. | ation: To B | axaminar? 1 Yas 2 Nd 27. Mannar of Death 1 Netural 5 Panding 2 Accident invastigatic | Hospitai: 1 Inpatiar 28a. Deta of Injun (Month, Day | | /Outpatient b. Tima of Injury | 28c. In | Othar: 4 Nu | rsing Hon | na 5 Rasid 28d. Dascribe h | ence 6 □Ott | |) | |
| IN SI | O CO | Certification: | 3 ☐ Suicida 6 ☐ Could not l 4 ☐ Homlcida datarmined | 2 | 28f. Location (S City or Tow | itreet and Numi n, Stata) | ber or Rura | Routa Nu | ımber, | | | | | |
| / | n 24 hour n 24 hour n Funera | edicai (| 29a. Cartifiar (Check only one) 1 Certifying Pl | nyalcian: To the best of miner: On the bests of and manner stat | axamination | dga, daath and/or inva | occurred et tha astigation, in my | tima, data an oplnion, daa | d placa, a | nd dua to tha cod at the time, d | ause(s) and m lata and placa, | annar as st and dua to | ated. the cause | R(S) |
| | To the within To the compl | M | 290. Signature and title of certifier 30. Nama and address of person who | completed cause of da | ath (Itam 23 | (Cla) (Type F | 29c. Lice | nsa number | 19 | 2 | 2 // 2 | ed (Month), I | Day, Year) | |
| | Sta | | Richard I, Ho 31. Deta filed (Month, Day, Yaar) | chman 2 32. Registra | 10 - | 18 | 33A | Form | (I) | r., An | napoli | 5, ha | Da | 40 |
| DH | Registi | | LER 1 3 1996 8 | relia Davidson- | Manda 80 | | | | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month Day Vaar G. Kar1 MCCORMICK February 9,1996 /Medical 8:12 PM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Rossville Baltimore If Undar 1 Yaar | If Undar 24 Hrs. Months | Days | Hours | Min. 5. Social Sacurity Number 8. Data of Birth 3 / 18 / 1935 7. Aga (In yrs. last birthday) Sex fv∃M 2□F 9. Birthplaca (State or Foreign **Funeral** Months Days WashingtonD.C Director 213-38-3418 60 Usual Rasidence of Decedant Peges 1 end 2 should be filed within 72 hours after death with the Manyland nent of Health end Mental Hygiene.
Instit filem 27 is marked other than "natural", or items 23s or 28s-4 show may or other theumatic event, if a Menjoil Experiment was be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits must be notified at Maryland Baltimore Middle River 1 Yas 20Klo Director 10e. Streel and Number 10f. Zlp Coda 10g. Citizen of What Country? 238 Riverthorn Road 21220 U.S.A. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2X No It Yas, Giva Yaar or Dalas: 1 Navar Marriad 2 X Married 21215-0020 1 ☐ Yas 2 No by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 10 Maintenance Housing Complex Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Karl G. McCormick, Sr. Mary Martina 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Brenda May McCormick 238 Riverthorn Rd. Baltimore, MD. 21220 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 2/13/1996 20a, Mathod of Disposition 20c. Location - City or Town, Stata 1 X Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of Important: If eny injury or Baltimore, Co. MD. Holly Hills Mem. Gardens 4 ☐ Donation 5 ☐ Othar (Specify) ature of Funeral Service Licensee 22. Nama and Addrass of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Balt., MD. 21221 lications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, one causa on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner a Dissection of Aortic Arch Minutes Dua to (or as a consequence of): Examiner b.Atherosclerosis or Attending Physician: The law requires that the deeth certificate be axecuted after death. Sequantially list conditions, if any, leading to immadiata cause. Entar Undarfying Causa (Disaase or Injury that initiated evants rasulting in death) Last and Dua to (or as a consequence of) P.O. Box 68760, ettending physician for use es the buria Physician/Medical Dua to (or as a consequence of) ed by the el detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d be detacl 1 Yes 20 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? Completed peed hes 1 XYas 2 No certificate Be 25. Was casa ratarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 Yas 2 No 1 🖾 Inpatiant 2 ER/Outpatient 3 DOA this funarel 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar ot Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Natural 2 Accidant death. 1 Yas 2 No Director 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28t. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 2 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a, Certifiar Medical 29b. Signatura and titla of certifian 29c. Licansa number 29d. Dala signed (Month, Day, Year) D17728 February 10, 1996 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Ba Yin Oung M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237 31. Data filad (Month, Day, Year) FEB 1 3 1996 432. Registrar Signature State

DHMH 16 Rev 6/95

Registrar

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Items 4c,19b 2-13-96 FilmG732 W.H.Per F/H Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygie Certificate of Death Reg. I 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month JAMES **EDWARD** MOORE FEB. 96 10 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death FROE FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 212-14-7848 OCT MD. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NE Yes 2□ No FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EAST FIFTH ST. 21701 U.S.A. 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Detes: 1942-43 1 ☐ Never Merried 2 ☐ Married 1□Yes 2No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) 6 TH LABORER CONSTRUCTION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) PRESTON MOORE, SR. MARGARET DIXON 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 118 EAST FIFTH ST. MOORE FREDERICK, MD. -20e. Method of Disposition
1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State Dete 4 ☐ Donetion 5 ☐ Other (Specify) RESTHAVEN MEM. GARDEN FEB. 14,96 FREDERICK MD. 21. Signature of Funerei Service Licenses 22. Neme end Address of Fecility 21701 GARY L. ROLLINS FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of Sying, such as carbiat or respiratory strest, shock, or head feiture. List only one cause on each line. FREDERICK tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concer of the Thront 73 months Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequenca of). that initiated events resulting in death) Last Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ▼ Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Box 68760. Division of Vital Records, P.O.

Examiner or Attending Physician: The law requires that the death certificate be executed and attending physiclan for use as the buria signed by the a d be detached f should should certificate this To the Hospital or Attending Privilla Within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

Physician

/Medicai

Examiner

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

10a. Stete

MD.

118

DORA

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If frem 27 is marked other than "natural" or the majour or other traumatic averages.

Physician

/Medical

Completed by Be 25. Wes case referred to medical examiner? Certification: To 1 Yes 2 No 27. Menner of Deeth 1 Neturel 2 ☐ Accident 3 Suicide 4 Homlcide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and pleca, end due to the cause(s) end manner steted. 29e. Certifier

29b. Signeture and little of certifier words a 17.

29c. License number 0-18191 29d. Date signed (Month, Dey, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) ANTANK G. MANAW MD.

187 Thron John D. Frederick, mp

State Registrar

Medicai

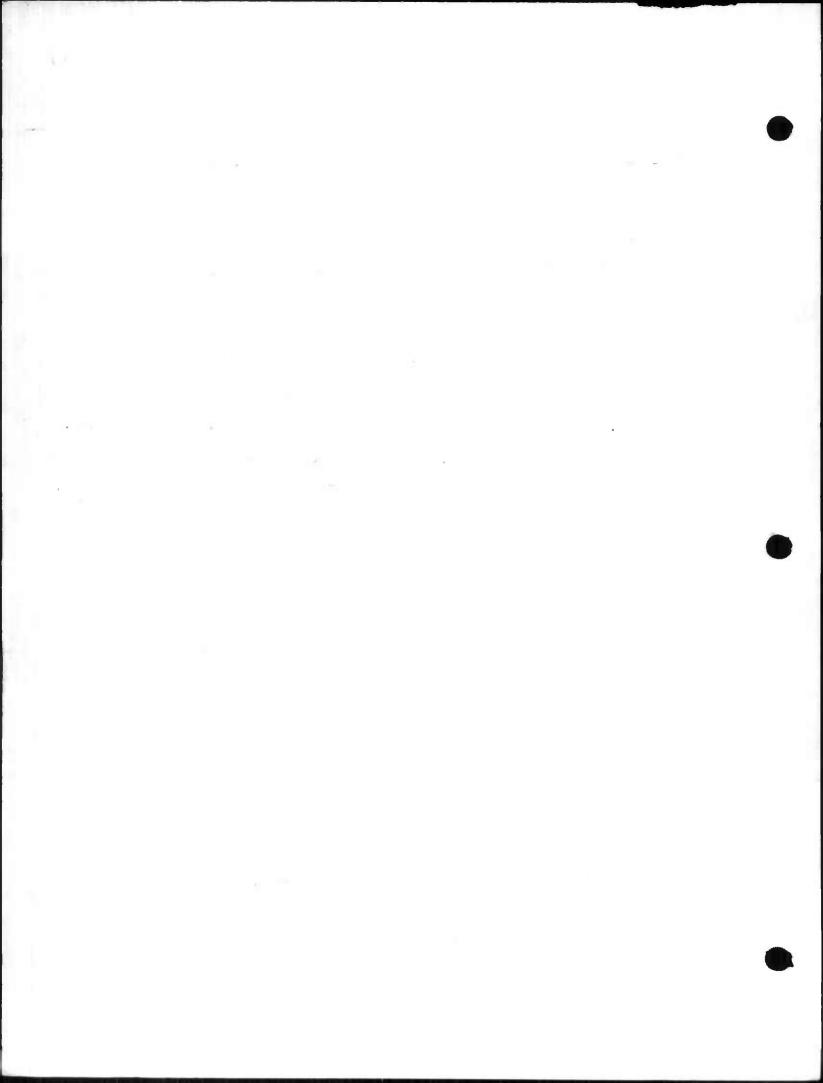
31. Dete filed (Month, Dey, Year) 32. Registrer's Signature 1996

Water and the Maria

THE FLICHTAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

| | ITEM: 3. PER DR. FILM G | -732 2/22/9 | 96 t.t | | | | | | 5 | U | 03310 |
|----------------------|---|------------------------------------|----------------------------------|----------------|----------------|--|----------------|-------------------------------------|------------|-------------|--|
| | REGISTRAR | STATE OF MAR | | | | IEALTH AND DEATH | MENTA | L HYGIEN | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) KATHERINE | | in Mi | | INF | TOWSKI | MONT | OF DEATH DA | 9,1 | YEAR 996 | 122 20 Am |
| á | 218-01-0400 | □ M 2 Ø F | AGE (In yrs. last birth | NONTH | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Monti | OF BIRTH 1, Day, Year) 2, 19 | | Country) | LACE (State or Foreign |
| NO. | 90. FACILITY NAME (If not institution, give street Good Samaritan Has | | | | | or LOCATION OF D | | | | N/A | ATH |
| DIRECTOR | GOOD SAMARITAN HOS RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c | CITY, TOW | | | | | | T | 10d. INSIDE CITY |
| | Maryland 100. STREET AND NUMBER | N/A | | Balti | | I. ZIP CODE | | | 40 - OITIT | | LIMITS? 1X YES 2 NO HAT COUNTRY? |
| FUNERAL | 916 South Ponca St | reet | | | 1 1 2 2 | 1224 | | | 101 | | States |
| BY FUN | | FORCES? 1 IF YES, GIVE WAR | YES 2 NO | 1 | If yes, sp | CENDENT OF HISPA ecify Cuban, Mexic 2 NO Speci | en, Puerto | f? (Specify Yea Rican, etc.) | or No- | Black, | - American Indian, Whita, atc. White |
| TED | 15. DECEDENT'S EDUCATI (Specify only highest grade con | ION npleted) | 18a. DECEDE (Give kin | d of work do | ne during me | ON ost of working | 16b | . KIND OF BUS | INESS/IND | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | maker | | | | Own Ho | me | | |
| | 17. FATHER'S NAME (First, Middle, Last) | • | | | | 18. MOTHER'S N | | | | | |
| O BE | Frank Pronthi 190. INFORMANT'S NAME (Type/Print) | | 19b. MAI | ILING ADOR | ESS (Street | Magael and Number or Rural | | Unkno ber, City or Town | | Code) | |
| TO | Marion I. Marcinkowski. 200. METHOD OF DISPOSITION \[\frac{200. METHOD OF DISPOSITION}{N\ \text{Burles} \ 2 \cdot \text{Cremetlor} \ \ 3 \cdot \text{Removal from State} \] 200. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetory or other place) 201. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetory or other place) St. Stanislaus Cem. 2/12/1996 Baltimore. Mark | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | 1 | I St. Sta | nisla : | US CO | ND ADDRESS OF F | ACILITY | 6 Ba | ltimo | ore. | Marykana |
| 4 | Duda-Ruck Funeral Home of Dundal. 7922 Wise Avenue Baltimore Mary 23. PART Letter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiec or recollatory great. | | | | | | | | | | |
| | 23. PART Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | Breast | Can (| | ting in the | underiyin | g cause given in | Part I. | 24s. WAS AN PERFOR 1 YES 2 | MED? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| AN: P | DID TOBACCO USE CONTRIE | BUTE TO CAUS | E OF DEATH | | | | N X | | | | |
| SICI | | IOSPITAL: | | ОТН | ER: | ne 5 🗆 Rasidence | 8 🗆 Othe | r (Specify) | | | |
| | 27. MANNER OF DEATH | 28a. DATE OF INJ (Month, Day,) | | TIME OF | 28c, IN | JURY AT ORK? | 7 | SCRIBE HOW I | NJURY OCC | URED | |
| red BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF IN building, atc. | IJURY — At home, II (Specify) | arm, street, 1 | factory, offic | | | CATION (Street a or Town, State) | and Number | or Rural Ro | oute Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL (Check only one) 2 MEDICAL EXAMINER: | | | | | | | | | | and manner as stated. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER N. Morboolle 30. NAME AND ADDRESS OF PERSON WHO CO | m , M. | ρ. | | | 29c. LICENSE NL | | 8 | | | Month, Day, Year) |
| | Nosser Manhoddem | - 1 - | | | 601 | Loch R | aven | Hosp | , Bo | et. | 1D 21239 |
| | FEB 1 3 1996 | 37 REGISTRAR'S | GNATURE | | | | | | | | |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03579

| | | | | | | | Certificate | e of | | noman rry | Reg. No. | 0 0 | | 13 | |
|---------------------|--|----------------|--|---|--|----------------------|--|-------------------|--|------------------------------|-----------------|---------------|---------------------------------|-------------------------|--|
| Г | Observator | | Decedent's Neme (First, Mid- | dle, Last) | | | | | | 2. Data of De Month | eth Dev | Year | 3. Ti | ma of Death | |
| J | Physici /Medic | | Bernard | Н. | Maus | | | | | | 9, 19 | | 4 | P.M. | |
| | Examir | | 4e. Facility Nama (If not instituti | on, give street end n | umber) | | | | 4b. City, Town, or L | | | ty of Death | | | |
| | | | 7344 Springfi | ield Ave. | | | | | Sykesvil1 | е | Can | rroll | | | |
| | Funeral | | 5. Social Security Number | 6. Sax | 7. Age (In yrs | . last birti | hday) If Undar | 1 Yeer Days | | 8. Data of Bir (Month, Da | th Vene | 9. Birthp | laca (S | tata or Foraign | |
| | Director | | 214 34 2851 | 1 □XM 2 □ F | 6 | i9 Y | /rs. Months | Days | Hours Min. | March 1 | 0. 192 | Carro | 11 | County | |
| | 2 | | Usual Rasidanca of Decedant | | | | | | | | | 7 | | | |
| | how | - | 10a. Stata 10b. Count | • | 10c. C | ity, Town | or Location | | | | | 1 | | de City Limits | |
| | e Me | cto | Md. Ca | arroll | | 5 | Sykesvil | 1e | | | | | 1 🕾 | Yes 2 No | |
| | 4 th | Director | 10e. Street and Number | | | | 10f. Zip | Coda | | | 10g. Citizen of | What Cour | ntry? | | |
| | th w | | 7344 Springs | field Ave. | | | 21 | 784 | | | U. 9 | S.A. | | | |
| | 72 hours effer death with the Maryland "natural", or ferms 23s or 28s-f show idical Examiner must be nutrited at | Funeral | 11. Marital Status | | cedent Ever in I | J,S. | 13. Wes Deced | ant of | Hispanic Origin? (Sp ben, Mexican, Puarto | ecify Yes or No | | ce - Americ | | an, | |
| 0 | or it | | 1 ☐ Never Merried 2 🔀 Ma | | 2XXNo | | 1 Yas 2 | | | rnoan, arc.) | | ack, Whita, | atc. | | |
| 02 | ref. | by | 3 ☐ Widowad 4 ☐ Divorce | ad Yeer or I | Datas: | | 1 1 1 1 1 2 | SEJ INU | эреспу. | | Spec | "y: Whit | e | | |
| 5-0 | within 72 ho jene. r than "netur tra Medical | Completed | 15. Deceda | ant's Education last grade completed | 0 | 16a. | Decedant's Usua | l Occu | pation during most of worked) | tina | 16b. Kind of | Businass/Ind | dustry | | |
| 21 | | P. | Elamentary/Secondary (0-12) | | (1-4or 5+) | | lifa. DO NOT us | e retire | ed) | | | | Center | | |
| 7 | | ဦ | High School | | • | Gro | ounds Fo | rem | an | | Springs | field | | | |
| P | 0 = 0 5 | Be | 17. Fathar's Name (First, Middle | i, Last) | | | | | 18. Mothar's Nam | a (First, Middla, | Maidan Suma | ıma) | | | |
| × 3a | | 2 | John S. Maus | 3 | | | | | Margar | et Ecke | r | | | | |
| Maryland 21215-0020 | 0 6 6 6 | | 19a. Informant's Neme/Raletion | iship (Type, Print) | | 19b. | Mailing Address | (Stree | t and Number or Rui | al Routa Numb | er, City or Tow | n, Stata, Zip | Code) | | |
| | 1 end 2 Heelth em 27 i | | Betty Jean Maus | 3 | | | | | eld Ave. | Sykesvi | lle, Mo | 1. 217 | | | |
| Ore | S T T | | 20e. Mathod of Disposition 1⊠ Buriel 2 ☐ Cramation | 2 Pamoual from | | Place of cematery | Disposition (Nam y, cramatory or of | na of thar ple | ece) | Data | 20c. Location | - City or To | own, Sta | .ta | |
| <u>B</u> | Peg nent imit: h | | 4 □ Donation 5 □ Other (| | | . Ma | arys Cem | ete | ry 2/1 | 3/96 | Silver | Run. | Md. | | |
| Baltimore, | permit. Pege Department Important: If any injury or once. | | 21. Signetura of Funaral Service | e Licansee | | | 22. Nama and | d Addr | ess of Fecility | | | | | | |
| m | 88 = 58 | | Ylam. 7 | 11 44 | 1+ | | D O Day | 7 | | ght Fun | | | | | |
| | | - | 23a. Pert1. Entar the disaasa, o shock, or heer, ailura. Lis | or complications that | caused tha daa | th. Do n | | | 95 Sykesv ing, such es cardiac | | | 54 | Appro | ximete | |
| 4 | Physician | | shock, or heer ailura. Lis | st only one causa #n | aach lina. | | | · | | | | | Intarva | al Between and Death | |
|)i | /Medical | | Immediata Causa (Final | Δ | - 17 (7. 1. Va | _ , | 4 . 4 | | | | | i | 4.0 | . /* | |
| | Examiner | | disaasa or condition rasulting in death) | a | TRRHY- | | | | | | | i | Wil | 42 | |
| | | Je | | Λ | - | 1 | onsequance of): | | r | | | | Mu | 21 | |
| | icate be executed physician and s the burial-transit | Examiner | Cognectieth, list conditions | b | | | MONAT | 27_ | EDEM | 1 | | - 1 | 1. (| ~/ | |
| Ó | exection and and and and and and and and and an | | Sequantially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disease or injury that light lead successions) | Δ | SCV | | onooquanoo oiyi | | | | | 1 | YICS | > | |
| 68760, | te be yslcii | edicai | miet ministen evante | C | | or as a co | onsequenca of): | | | | | | | | |
| | E 0 6 | Pa | rasulting In daath) Lest | 1. | | | | | | | | | YR | 5 | |
| Вох | | Z | | d | TIFE | -16 | NSION | | | | | | /! - | | |
| œ. | death ce | Physician/M | Part II. Other significant condit | lons contributing to d | death but not ra: | sulting in | tha underlying ca | ause oi | iven in Pert I. | 23b. Did | tobacco use c | ontribute 1 | the ca | use of death? | |
| P.O. | by th | hys | | 0.0 | | Julius III | and andonying oc | auco gi | | | Yes 2 No | | | 4 ₩ Unknown | |
| S, F | | by P | DIABETES | (VLELLI | TUS | | | | | | 100 213110 | 0 | ., | No. | |
| ğ | requires | | | | | | | | | | an autopsy | 24b. W | ere auto | psy findings | |
| Vital Record | - A2 (0) | Completed | HYPERTEN | SIVE CA | 2010 | ~70 | PATHY | | | perio | rmed? | CO | elleble p mplation death? | n of causa | |
| Be | The law ate hes b page 2 s | Ę | | | | | • | | | | M. | | | den | |
| B | certificate rector, pag | | 25 Was soon referred to media | ol. | | | | | | 10 | | 11. | Yas | No No | |
| ₹ | Physician: this certific ral director, | Be C | 25. Was casa refarred to medic exeminar? | Hospital: | | | | Ot | 26. Pleca of Deat | 14 | | | | | |
| o | Phys | 2 | 1 Yes 2 No 27. Mannar of Deeth | 28a. Deta | | 28b. Ti | | ^ | ALI Nursing Ho | 28d. Dascribe | dance 8 0 | | y) | | |
| on | Attending ir death. actor: After by the fune | io | 1 Neturel 5 ☐ Pand | | nth, Day Year) | | jury M | Bc. Inju Wo | ork?]Yes 2 □ No | | ion injury cook | | | | |
| S | deat deat ctor: y the | lica | 3 Suicida 6 Could | not be | e of Injury - At h | ome fen | m, straat, factory, | | | 28f. Location (| Streat and Nun | oher or Rum | I Route | Number | |
| Division | or after Direction | Certification: | 4 Homicida dater | minad 20a. Plac | ling, atc. (Speci | fy) | iii, stiaat, laotory, | , 011100 | | City or To | vn, Stata) | 1501 01 11510 | | . voinibor, | |
| | ours eral | | 29a. Cartifier 1□ Certify | ing Physician: To th | a beet of my kn | oulodae | dooth coourred a | at the ti | mo data and place | and due to the | seves(s) and s | 222222 | tated | | |
| | To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director. | edical | | ing Physician: To the il Examiner: On the b and man | a best of my kno basis of examino oner stated. | etion and | or Invastigation, | in my | opinion, daath occur | red at tha tima, | data end plece | , and dua to | tha ca | use(s) | |
| | ithin o the omple | Me | 29b. Signeture end title of certifi | | vialeu. | | 29c | Lican | ansa number 29d. Data signed (A | | | | Dav. Ya | (ar) | |
| | F ≯ F ŏ | | DL' - | N D | ~ | | | | | | · Err | 1 | 10 | G/- | |
| | | 4 | Theep | SIV. FA | ree | 347 | | V | 36908 | , | IEE | . 14 | 17 | 76 | |
| | | & | 30. Nama and eddrass of person | who complated cau | isa of death (Ita | m 23a) (1 | | | 7690E | EBC | 70. | MT | > 7 | 1131 | |
| | | | 31. Data filed (Month, Day, Yagi | DE151 | Benificar's Sign | O'CC | O KD | >< | 11417 | -101 | UNN | 1 | | -1.70 | |
| | Sta Registr | | FEB 1 3 199 | 6 Jubia | Registrer's Sign | 164 | | | | | | | | | |

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

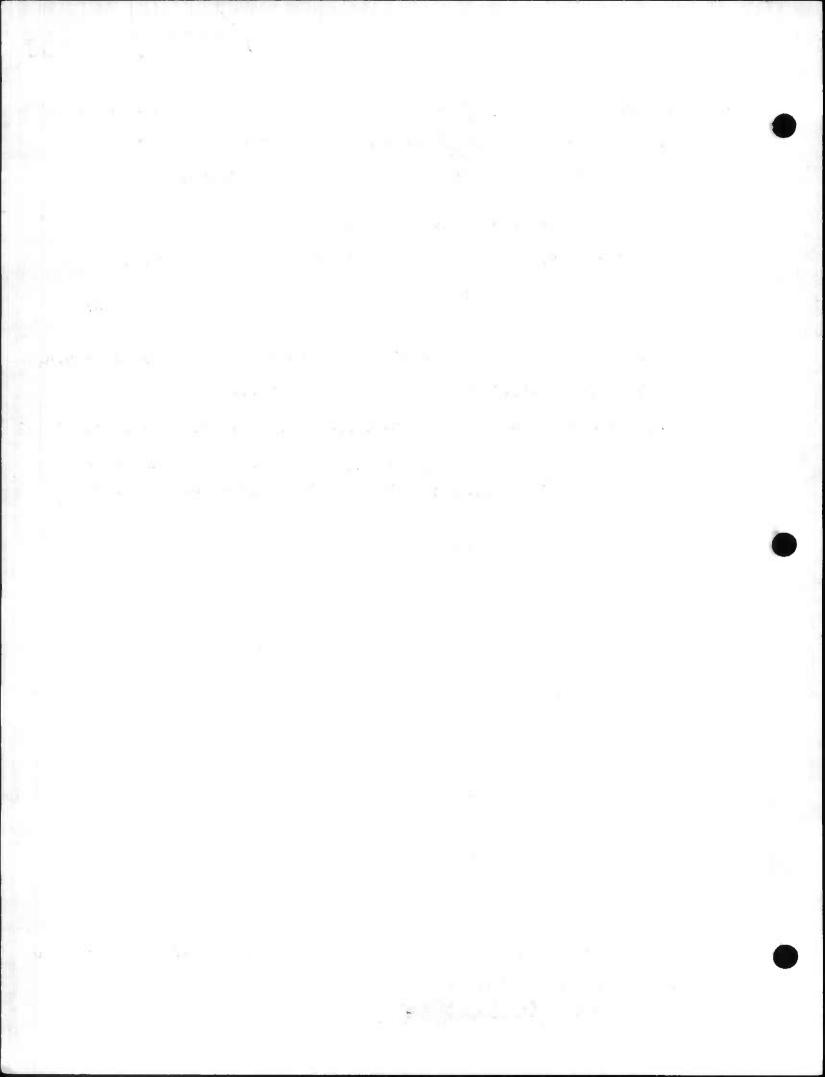
State of Maryland / Department of Health and Mental Hygiene 96 03580

| | | | | | | Certifi | icate of | Death | | Rec | 2. No. | , 0 | | , , | | |
|------------|--|----------------|---|---|----------------------------------|-----------------------------|---|--------------------------------------|---------------------------------|---|--------------------------------|---|---|----------------|--|--|
| | ALC: U | | 1. Decedant's Nama (First, Middla, Las | it) | | | | | | ita of Death | | 7 | 3. Time o | of Death | | |
| | Physici | | GLADYS M. NASH | | | | | | M FE: | onth BRIIARY | Day 7 9, 19 | Year 996 | 5:45 | A.M. | | |
| ١. | /Medi Examir | | 4a. Facility Nama (If not institution, give | street and number) | | | | 4b. City. Tow | m, or Location | | 4c. County | | 0.110 | ***** | | |
| 1 | LXGIIII | ici | MINK HILL ASSISTE | ED LIVING | HOME | | | GRASON | | | QUEEN | | 10 | | | |
| Ī | Funeral | | 5. Social Sacurity Number 6. Sa | | (In yrs. last bin | | Undar 1 Yaa | If Undar 2 | 4 Hrs. 8. Da | ita of Birth onth, Day, Y | 'ear) | 9. Birthpl Count | aca (Stata | or Foraign | | |
| | Director | | Usual Rasidance of Dacedent | | J | | | | SE. | PT. 30 | ,1915 | MARY: | LAND | | | |
| | land ow | | 10a. Stata 10b. County | | 10c. City, Town | or Location | on | | | | | 10 | Od. Insida C | City Limits | | |
| | Sa-f sh | Director | MARYLAND QUEEN AN | INE'S | STEVEN | SVILL | E | | | | | | | s 2 No | | |
| | th with th | | 10e. Street and Number 106 TOWER DRIVE | | | | 0f. Zip Code 21666 | | | |). Citizen of V JNITED | | | | | |
| 21215-0020 | filed within 72 hours after death with the Meryland Hygiene. Idher than "natural", or Hema 23a or 28a-f show ont, the Medical Examiner must be moffled at | by Funeral | 11. Marital Status 1 □ Nevar Married 2 □ Married 3 □ ŠWidowad 4 □ Divorced | 12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: | | If Yas | Dacedant of s, specify Cul Yas 2 No | Hispanic Original, Maxican, Specify: | in? (Specify Y Puarto Rican, | as or No- atc.) | Blec | a - Amarica ck, Whita, a | atc. | | | |
| 5-0 | 72 ho | ted | 15. Decedant's Ed (Specify only highast grad | ucation | 16a. | Decedant's | s Usual Occu | pation | of working | 16 | 6b. Kind of Bu | usiness/Ind | ustry | | | |
| 121 | jene. | Completed | Elamentary/Secondary (0-12) | Coilega (1-4or 5- | | | VOT usa retin | during most | or working | 17 | OOD CE | DITTO | | | | |
| 7 | e filed within al Hygiene. other than vent, the M | | 17 Fatharia blama / First Middle 1 and | 3 | CO | JK. | | 46.14.4 | | | OOD SE | | 5 | | | |
| Maryland | of its of | Be | 17. Fathar's Nama (First, Middla, Last) | | | | | | 's Nama (First | | | a) | | | | |
| Š | should be i and Mental I s marked of iumatic eve | 10 | WALTER J. JOHNSON | | Total | | | | A STING | | - | | | | | |
| Ma | d 2 should th and Mer 7 is marks traumatic | | 19a. informant's Name/Ralationship (7) WALTER G. NASH | ype, Print) | | | | t and Number | | | | | | | | |
| | | | 20a. Mathod of Disposition | | 20b. Placa of | | | VE, ST | | | | ARYLAND 21666 Location - City or Town, Stata | | | | |
| Baltimore, | permit. Peges 1 ar Department of Hea Important: If Item 2 any Injury or other ODGS.: | | 1 ☑ Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | y, cramato | ry or othar pla | | B. 12, | 14 | LEN BU | | age senanti | YLAND | | |
| Ball | Depart Import any inj | | 21. Signature of Funeral Service License | l' 1 | | | | ass of Facility | | | | | | | | |
| | _ | | 23e. Pert1. Enter the disaasa, or comp shock, or haart failura. List only of | lications that causad t | tha daath. Do r | | | HWY., | | | | , MD | 21061 Approxima | | | |
| и | Physician /Medical Examiner | | snock, or haart failura. List only of Immediate Ceusa (Final disaasa or condition rasulting in death) | | l 70 | - 1 | | | | | | | Interval Be Onset and | Death | | |
| | | Je. | rasuming in Gaatily | 11 | Dua to (or as a consequence of): | | | | | | | | . 1. | | | |
| | artificate be executed Ing physician end e as the buriel-trensit | Examiner | Coguentially list conditions | b. M | 1 | puters in a consequence of: | | | | | | | | m | | |
| ó | certificate be executed uding physician end use as the buriel-trensit | | if any, laading to immediate causa. Enter Underlying Causa (Disaasa or Injury | | | | | | | | | | | | | |
| 68760, | the bu | Medical | that initiated evants rasulting in death) Last | c | ua to (or as a c | onsequenc | e of): | | | | | | | | | |
| 9 × | Ing p | Mec | | | | | | | | | | İ | | | | |
| Bo | 2 0 0 | an | | d | - | | | | | | | 1 | | | | |
| | the atter the atter hed for u | sici | Part II. Other significant conditions co | ntributing to death but | not resulting in | tha undari | lying causa g | ivan in Part I. | 2 | 3b. Did tobe | ecco use cor | tribute to | the cause | of death? | | |
| P.0 | ed by detac | / Physician/ | | | | | | | | 1 🗆 Yes | 2 1 No | 3 Prob | ably 4□ | Unknown | | |
| Records, | e lew requires hes been sign je 2 should be | Completed by | | | | | | - | 2 | ta. Was an a | autopsy ed? | ava | ra autopsy ilabla prior apletion of laath? | to | | |
| | 0 5 0 | E | | | | | | | | 1 ☐ Yas | 2 🖾 No | 10 | Yas 2 |] No | | |
| | delan: The | Be | 25. Was casa rafarred to medical | | | | | 26. Place of | of Death (Che | ck only ona) | | | | | | |
| > | Physician: this certific | 0 | axaminar? 1 ☐ Yas 2 ☐ No | Hospital: 1 ☐ Inpatian | t 2 ER/Ou | toatient 3 | DOA O | har | sing Homa 5 | | | ar (Specify |) | | | |
| of | er thi | n: T | 27. Mannar of Death | 28a. Deta of Injury | 28b. T | ima of | 28c. inju | | | | Injury occurr | | | | | |
| 9 | ath. : After e fune | atio | 1 ☑Natural 5 ☐ Panding 2 ☐ Accidant Invastigation | (Month, Day | Year) In | njury N | | onk/]Yas 2∐N | 0 | | | | | | | |
| Divis | To the Hospital or Alta ding Ph within 24 hours effer deeth. To the Funeral Director: Affer th completely filled in by the funeral | Certification: | 3 Suicida 6 Could not be 4 Homicide determined | 28a. Place of Injur building, etc. | | | | | | | et and Numbe Stata) | er or Rural | Routa Nun | n <i>ber</i> , | | |
| | Hospita 24 hours Funeral etely filled | edical | 29e. Certifiar 1 Certifying Phy (Check only one) | sician: To the best of iner: On the basis of a | examination and | deeth occ | urred et tha t gation, in my | ima, data and oplnion, daath | placa, and du occurred at t | a to tha cau ha tima, data | se(s) end me a and place, e | nner as sta and dua to | ated. tha causa(| s) | | |
| | To the Within 2 To the comple | Me | 29b. Signature and little objectities | / | | | | | | 290 | i. Data signed | d (Month, L | Day, Year) | | | |
| | - s + o | | Nonus | milles 037064 | | | | | | 29d. Data signed (Month, Day, Year) FEBRUARY 9, 1996 | | | | | | |
| | U | 1 | Nama and address of person who co | ompieted causa of da | ath (Itam 23a) (| Type, Print | | - /- 0 | | | | | | | | |
| _ | 1 | | MES M. CHAMBERI | | | | | RM RD. | , ARNO | LD, MA | RYLAND | 210: | 12 | | | |
| m | Sta | te | 31. Data filed (Month, Day, Year) | #32. Augistra | Color | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 03581

| | | | | , | Certific | ate of | Death | , | Reg. No. | | |
|---|----------------|---|--|-----------------|-------------------------------------|---------------------------|--|--|-------------------------------|----------------------------|-------------------------------------|
| Di- | | Decedent's Name (First, Middla, La. | 3 | | | | | 2. Date of Dea | | Yaar | 3. Tima of Death |
| Physic /Medi | | LAWRENCE | - OBRI | EN | JR. | | | FEB RUA | RY-13- | 1996 | 10.05 AM |
| Exami | | 4a. Facility Name (If not institution, give | a street and number) | | | | 4b. City, Town, or I | | | | |
| | | HARBOR HOSPITAL CO | ENTER, 300 | 1-5.H | ANOVERS | ST. | BALTIMO | TE MD | ^ | MA | |
| Funeral Director | | 5. Social Security Number 6. S | ex 7. Aga | (In yrs. last b | | dar 1 Yaar | If Undar 24 Hrs. | | , Year) /25 | 9. Birthpla Counti | nce (State or Foreign ry) Md. |
| puel ** | | 10a. State 10b. County | | 10c. City, To | wn or Location | | | | | 10 | d. Inside City Limits |
| Mary 1 sh | 0 | Md. Anne A | Z11 2 2 2 1 | Die | | D | 1. | | | | 1 ☐ Yes 2 🗷 No |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Director | 10e. Streat and Number | runder | KIV | viera | Beac Zip Coda | n | | 10g. Citizen of | What Count | n/2 |
| WIE O | | | ~ ~ d | | 1011 | | 00 | | | | ,,, |
| 23 at | era | 8440 Church R | 12. Was Decedant Ev | ver in II S | 13 Was Da | 211 | | nacifu Van or No. | | S.A. e - Amarica | n Indian |
| owning / 2. nouts ariser death with the Maryland jene. Then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at | by Funeral | 1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forcas? 1 Mayes 2 Mo If Yes, Give Year or Datas: | | | | Hispanic Origin? (S pan, Mexican, Puert Specify: | o Rican, etc.) | Bla Specif | ck, White, e | |
| 2 hot | P | 15. Decedent's Ed | lucation | | a. Decedent's U | sual Occu | petion | | 16b. Kind of B | | |
| | Completed | (Specify only highast gra | de completed) | | (Give kind of life. DO NO | work done T use retire | during most of wor | rking | | | , , |
| Hygiene. ither than " ant, I'm Mar | E | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | Worker | | Nation | 001 E | BrewingCo |
| 五 · · · · · · · · · · · · · · · · · · · | | 17. Father's Name (First, Middle, Last) | | 4 4 | ·ouuco | 1011 | | ne (First, Middle, | | | rewringco |
| h and Mental Hygi 7 Is marked other treumetic svent, I | To Be | Lawrence L. | O"Brien | Sr | | | Ma | rie Bol | an. | | |
| marri medi | 1- | 19a. Informant's Name/Relationship (| | | h Mailing Addr | ess (Stree | t and Number or Ru | | _ | State 7in (| Code) |
| | | | | | | | | | | | |
| PEG | | Antoinette O'B | rien | 20b. Place | of Disposition (| Name of | 1 | Date | 20c. Location | | 1d. 2112 |
| 0 | | 1 ☐ Burial 2 M Cremation 3 ☐ | | ice) | | | | | | | |
| Department Important: If any Injury o | | 4 Donation 5 Other (Specify | | /14/96 | Catons | svill | e, Md. | | | | |
| mpo my li | | 21. Signature of Funeral Service Licenter | 0 | // | | | Funera: | Home o | f Pasa | adena | |
| .0260 | | Cugun | Carel | V | | | untain] | | | | |
| | | 23a. Part1. Enter the disease, or company shock, or Heart failure. Line only | olications that caused the | ne deeth. Do | not enter the n | node of dy | ing, such as cardiac | or respiretory ar | rest, | | Approximate Interval Between |
| ysician | | | | | | | | | | | Onsat and Death |
| Medical | | Immediete Cause (Finel disease or condition | CHRI | ONIC | RENA | L F | AILURE | | | | |
| aminer | | resulting in death) | d | - | consequence | | | | | | |
| بسبب | ner | | | | | 1 | .1 Dosis | | | | 6 DAYS |
| dransi | Examiner | Sequentially list conditions | b | ue to (or as a | consequence | of): | ., | | | | 021112 |
| rial-t | | Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury | | | | | ART FA | 11 11 0= | | | |
| physician end s the burial-transit | Medical | THAT FIREMED EVANTS | | | consequence of | | AKIFA | ILURE | | - | |
| es th | P | resulting in death) Last | Di. | 10 (01 a5 a | consequence | η. | | | | | |
| July 88 | 3 | | d | | | | | | | | |
| attendin for use | ciai | | | | | | | | | i | |
| igned by the a | Physician/ | Part II. Other significant conditions of | ontributing to death but | not resulting | in tha underlyin | g cause gi | ven in Part I. | 23b. Did t | obacco uss co | ntribute to | the cause of death? |
| deta deta | | | | | | | | 101 | es 2 No | 3 Probi | ably 4 🗍 Unknown |
| Sign De Sign | 1 by | | | | | | | 04-14- | | Oth Was | ra autopsy findings |
| been si should | Completed | | | | | | | | an autopsy med? | aval | liable prior to |
| 2 0 | npfu | | | | | | | | | of de | eath? |
| | Ö | | | | | | | 1 🗆 Y | es 20 No | 10 | Yas 20 No |
| certificate rector, pay | Be (| 25. Was case rafarred to medical examiner? | | | | | 26. Piace of Dec | eth (Check only o | ne) | | |
| o 0 | 2 | 1 Yes 2 No | Hospitei: | 2 ER/0 | utpatient 3 | DOA Ot | her: 4 Nursing H | lome 5 Rasid | ence 8 Oth | ar (Specify) |) |
| er th | | 27. Manner of Death | 28a. Dete of Injury (Month, Day) | 28b. | Tima of | 28c. Inju | ry at | 28d. Describe h | ow Injury occur | red | |
| er death. rector: After t by the funer | atlo | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | | ou/) | Injury M | | Yes 2 No | | | | |
| after deat Director: I in by the | 110 | 3 Suicide 6 Could not be determined | 28a. Placa of Injury | / - At home, f | arm, street, fac | tory, office | | 28f. Location (S | treet and Numl | ber or Rural | Route Number, |
| Dire | Certification: | 4 Homicide | building, efc. | (Specify) | | | | City or Tow | n, State) | | |
| To the Funeral Dire | edicai C | 29a. Certifier 1 Certifying Physical Check only one) 2 Madical Example 1 | ysician: To the best of a liner: On the bests of ea and manner state | xamination a | e, death occurr nd/or investigat | ed at the ti | me, date and place opinion, deeth occu | , and due to the or rred et the time, o | ause(s) and malete and placa, | anner as sta and due to | ited. the cause(s) |
| o a | Me | 29b. Signature and title of contifier | | | | 29c. Licen | se number | | 29d. Date signe | d (Month, D | ay, Year) |
| 5 ⊢ 10 | | A and | M N | | | | | | _ | | |
| Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan | | 30. Name and address of person who of TAR IQ MIR 3A, 7/1/5 | ゴ・ル、 | | / | 452 | 44/6/4-3 | 6 | EBRUAR | 2 Y-1 | 3-1996 |
| 1 | | 30. Name and address of person who | completed cause of dea | th (Item 23a) | (Type, Print) | | 0 | | | 91.14 | |
| 11 | | 1 ARIQMIRZA, 7115 | #D, KOLLIN | 16 BEA | 1) KOAL | 0) / | SALTIMO | RE, ~ | 1.0 21 | 244 | |
| Sta | ite | 31. Dete filed (Month, Day, Year) | del 32 Begistrar | Signature | 00 | | | | | | |



$\begin{array}{c} \text{Item1} & 2-13-96 \quad \text{FilmG732} \quad \text{W.H.Per } \text{F/H} \\ \text{Please Type or Print in Black Indelible Ink.} & \text{Assure All Copies Are Legible.} \end{array}$

State of Maryland / Department of Health and Mental Hygiene 96 03582

| | | | | Cei | rtificate of | Death | F | leg. No | | |
|----------------------------|--|-----------------|--|-------------------------|--------------------------------|---|------------------------------------|---|-------------------|---|
| | Physici | an | 1. Decedant's Neme (* Jeshia Artimis Lat: | | ttman | | 2. Dete of Dee | th New Ye | | Time of Deeth |
| J | Physici /Medi | | | TIMAN | • | | FEB. (| 199 ^Y | 5 5 | :22 PM |
| ı | Examir | | 4a. Facility Name (If not institution, give street and number) BON SECOUR HOSPITAL | | | 4b. City, Town, or Lo BALTIMO | | 4c. County of t | /A | |
| | Funeral Director | | 5. Sociel Security Number 6. Sex 1 M 20 F Usuel Residence of Decedent | rs. last birthdey) Yrs. | If Under 1 Year Months Deys | | 8. Dete of Birth (Month, Day | Year) 1994 M | Country) | (State or Foreign |
| | hours after death with the Maryland ural, or flems 23a or 28a-f show at Examiner must be notified at | tor | 10a. Stete 10b. County 10c. (| City, Town or Lo | | | 55.00 | | | nside City Limits |
| | in 72 hours after death with the Marylar "natural", or Items 23a or 28a-1 show | I Director | | 6 | 10f. Zlp Code | 1417 | 1 | Og. Citizen of Wha | t Country? | |
| | death | Funeral | 11. Maritel Stetus 12. Wes Decedent Ever in | U,S. 13. | | Hispenic Origin? (Sp | ecify Yes or No- | 14. Rece - / | | idien, |
| 020 | ours after al', or its | þ | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Detes: | | 1 Tes, specify Cul | | Hican, etc.) | Specify: | White, etc. Blac | Ac. |
| 5-0 | 27 an an | eted | 15. Decedant's Education (Specify only highest grade completed) | 16e. Decer | dent's Usuel Occu | spetion during most of work | ina | 16b. Kind of Busin | ass/Industr | У |
| 21215-0020 | with than | Completed | Elementary/Secondery (0-12) College (1-4or 5+) | life. I | DO NOT use retin | ed) | any . | M | A | |
| Maryland | S as S | To Be | 17. Fether's Name (First, Middle, Last) | Se. | | 18. Mother's Nem | e (First, Middle, i | Maiden Sumame) | | |
| lan | 2 should and Mer is marks | | 19e. Informent's Neme/Reletionship (Type, Print) | | ng Addrass (Stree | et and Number or Run | al Route Number | , City or Town, Sta | te, Zip Cod | (e) |
| | 1 and Health am 27 ther tr | , | SHARIL. HALL, Mother | 1635 | LOCAL OSITION (Name of | nan Ct. | | MUTE, M | 12/0 | 17 |
| Baltimore | 0 m 0 m 0 | | 1 Surial 2 □ Cremetion 3 □ Removel from Stete | cemetery, crer | matory or other pla | aca) | Dete 3-10-90 | 20c. Location - City | or lown, | State |
| Ė | E 40 22 | V i | 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee | RBUTU | 2. Name end Addr | ess of Fecility 53 | VORE | STERGOUS | 5 11 | en en |
| B | Depart Depart Import any inj | | Suray April | C | WATMAN | - Harris | I.W. B | stimore | | 2/2/2 |
| | | | 23a. Party. Entar tha disease, or complications that caused the da shock, or heart feilure. List only one ceuse on each line. | eth. Do not ent | er the mode of dy | ing, such es cardiac | or respiretory err | est, | Inte | roximete rval Between |
| 1 | Physician /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in deeth) | (or es a consec | Tak | elation | | | Ons | et end Deeth |
| | b iz | lner | | | | | | | į. | |
| 50, | ertificate be executed ling physician and e as the burlal-transit | Il Examiner | Sequentially list conditions, if eny, laeding to Immadiate cause. Enter Underlying Cause (Disease or Injury | (or es e conseq | quence of): | | | | | |
| ox 68760, | certificate be executed of ing physician and use as the burial-transit | VMedical | that initieted evants resulting in death) Last | (or es a conseq | juenca of): | | | | | |
| Bo | seath affor u | clar | Dort II. Other significant conditions contribution to death by any angle of the contribution of the contri | a dela de ale a de a | | Land La Parada | I am pu | | | |
| P.O. | requires that the death cent een signed by the attendin hould be detached for use | / Physician/ | Pert II. Other significant conditions contributing to death but not re | sutting in the ui | ndenying cause g | ven in PeπI. | 236. Did to | es 2 No 3 | | deuse of death? 4 □ Unknown |
| Division of Vital Records, | w requires been sign should be | Completed by | | | | | 24e. Wes e | | evallebi | utopsy findings e prior to to cause |
| æ | The law ate has b page 2 s | mo | | | | | 1 U Y | es MNo | | 2 □ No |
| īa | sician: The certificate rector, pag | Bec | 25. Wes case referred to medical | | | 26. Place of Daat | | | | |
| 2 | Physician: r this certific and director, | 2 | | ER/Outpatien | nt 3 DOA | ther: 4 \sum Nursing Ho | me 5 Reside | enca 6 Other (| Specify) | |
| NC. | Hing P | lon: | 27. Menner of Deeth 1 Natural 5 Pending (Month, Day Year) | 28b. Time of Injury | W | | 28d. Describe h | ow Injury occurred | | 0.00 |
| Sic | death ctor: y the | ficat | 2 Sucident investigation Sucident Sucid | home farm str | | Yes 2 No | 28f. Location (S) | treat and Number of | or Aural Rou | de Number. |
| <u>S</u> | after after Dire | Certification: | 4 Homicida determined 28e. Piece of Injury - At building, etc. (Special Control of the Control o | lesi. | len e | | City or Town | n, Stata) | A | Ne |
| | To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | edical | 29e. Certifier (Check only (C | nowledga, deeth | n occurred et the t | ima, date end place, opinion, deeth occurr | and due to the cred at the time, d | ause(s) and manna ete and plece, and | r es stated | cause(s) |
| | thin 2 the mple | Med | 29b. Signature and title of certifier | | | se number | | | | |
| | 5.2 ± 8 | | D () = (= (= ()) () |) | | C.M.E. | | 9d. Dete signed (M FEB. 05 | • | |
| | | | 30. Neme end address of person who completed cause of deeth (lite | am 23a) /Tuna | | | | | , -, | |
| | | | | | | eet, Bal | timore. | Marvla | and 2 | 1201 |
| | Sta | te | 31. Dete filed (Month, Day Year) 996 | new Landall | | , | | | | |
| | Registr | ar | LEDIO 1990 Day | | | | | | | |

| BALTIMORE, MARYLAND 21215-0020 | rSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | ion, or removal. | the medical examiner must be notified at once. |
|---|--|---|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | IN THE HIGH TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | IN THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely | or men with a prior after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. | IMPORTANT if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 . STATE | STATE OF I | MARYLAND / | | | | | | MENTAL | . HYGIEN | IE . | 0 | 03303 |
|---------------|---|--------------------------|---------------------------------------|-------------|---------------|-------------|-----------------|-------------|-------------|---------------------------------|-------------|-------------|---|
| \neg | REGISTRAR | | CE | :RIII | ICATE | : OF | DEA | TH | | REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) VINCENT J | PEFFER | JR. | | | | | | 2. DATE | | 8 9 | YEAR | 3. TIME OF DEATH |
| - 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER | t YEAR | IF UNDE | R 24 HRS. | 7. DATE | OF BIRTH | | S. BIRTH | IPLACE (State or Foreign |
| | 162-44-1343 90. FACILITY NAME (If not institution, give str | 1 M 2 F | 42 | YRS. | MONTHS | DAYS | HOURS | MIN. | Anf. | ot 12 | 1953 | Pen | nsylvania |
| DIRECTOR | THE JOHNS HOPKINS | | L | | | | | CITY | | | 9c. COU | NTY OF E | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | 11/ | |
| R | 10e, STATE 10b, COUNTY | | | | TY, TOWN C | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | Pennsylvania Lanca | aster Co | unty | Ed | en To | _ | hip | Œ | | | 10g, CIT | IZEN OF | 1 YES 2X NO |
| FUNERAL | 139 Groff Road | | | | | , | 17566 | 5 | | | | U.S. | A |
| ž | 11. MARITAL STATUS | 12. WAS DECEDEN | IT EVER IN U.S. AR | MED | 13. | _ | | | NIC ORIGIN | ? (Specify Ye | _ | | A • E — American Indian, |
| BY FL | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? | YES 2 XN | Ю | | If yes, sp | ecity Cubi | | n, Puerto F | | | Blac | k, White, etc. |
| | | | | | | | | | | | | | Milec |
| TED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | (Gi | ive kind of | work done | | | ing | 16b. | KIND OF BU | SINESS/INI | DUSTRY | |
| H | Elementery/Secondery (0-12) | College (1-4 or 5 | +) | | ise retired.) | | | | | | | | |
| COMPLET | 12th grade | | Con | istri | ictio | n Wo | | | | nstru | | Con | npany |
| | 17. FATHER'S NAME (First, Middle, Last) Vincent J. Peffer | Sr | | | | | 100 | | | Middle, Meiden | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | 51. | 198 | . MAILING | 3 AOORES | S (Street) | | | | raybi. | | n Codel | |
| 5 | Wanda Peffer (Wif | (a) | 1. | 39 G | roff | Roa | "Qua: | rryv | ille | Donn | 032 132 | nio | 17566 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | | | | | | DAT | | CATION - | | |
| | 1 | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | |
| | 111111 | // | | | | | | | | Home | | | |
| _ | | | | | | | | | | | | | ryland 21213 |
| | 23. PART i. Enter the disease, or c shock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition | List only one ca | use on aach iina | b | | | | | | | | | Approximate interval Between Onset and Death |
| | resulting in death) | | (OR AS A CONSE | DUENCE C | DF): | | | | | | () | | 10 days |
| ON | Sequentially list conditions, | Allog J | OR AS A CONSE | DUENCE | C N | nar | row | , tr | ans | plant | ati | on | 13 days |
| CAT | if any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury | Cito | xen- | TB | I | m | lik | CON | 1/2/ | ~ | | | 20 das |
| Ē | that initiated events | DUE TO | (OR AS A CONSEC | DUENCE C | OF): | | . 1 | . / | | 1 | | | 9 1 |
| CERTIFICATION | resulting in death) LAST | . FEIN | very ~ | ebr | acto | 7 | Hoo | tsh | ins | dis | eas | e | - months |
| | PART II. Other significant condition | s contributing to | daath but not r | esulting | In tha ur | nderlyin | g cause | given in | Part I. | 24a, WAS AF | N AUTOPSY | 24 | . WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICAL | | | | | | | | | | t TYES | | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | /\ | | 1 YES 2 NO |
| | | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | |
| YSI | 1 YES 2 CHO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | | | | |
| PH | 27. MANNER OF DEATH | 28e. DATE O | | 28b. TII | ME OF | | JURY AT DRK? | | 28d. DES | CRIBE HOW | INJURY OC | CURED | |
| В | 1 Natural 5 Pending 2 Accident Investigation | | | | М | | YES 2 | NO | | | | | |
| ED | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE (building | OF INJURY — At ho , etc. (Specify) | me, ferm, | street, fec | tory, offic | ce | | | ATION (Street or Town, State | | or or Rural | Route Number, |
| ET | | | | | 2-5 | | | | | | - | | |
| COMPLET | 29e. CERTIFIER (Check only one) | | | | | | | | | | | | |
| Ö | 2 MEDICAL EXAMINE | R: On the besis of | exemination end/or | investigati | lon, In my | opinion, (| death occu | ured at the | time, date | end place, e | nd due to t | the cause(| e) end menner es stated. |
| BE (| 296. BIGHATURE AND TITLE OF CENTIFIE | > | 01 1 | | . 13 | | | CENSE NU | | 1 | 29d. DA | TE SIGNE | O (Month, Day, Year) |
| 10 | Robert & all | O mo | Polert J | | | MD. | MD | 0481 | 521 | - (PA) | 1 8 | s fe | 5 96 |
| | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | | | | |
| | ROBERT J CHRISTIE | | | OPKI | NS H | OSPI | TAL, | 600 | N WO | LFE SI | .,BA | LTO. | MD.21287 |
| | FEB 1 8 1996 | Jalia de | AR'S SIGNATURS | 464 | | | | | | | | | |

10

DHMH-16 Ray 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are

State of Maryland / Department of Health and Mental Hygiene

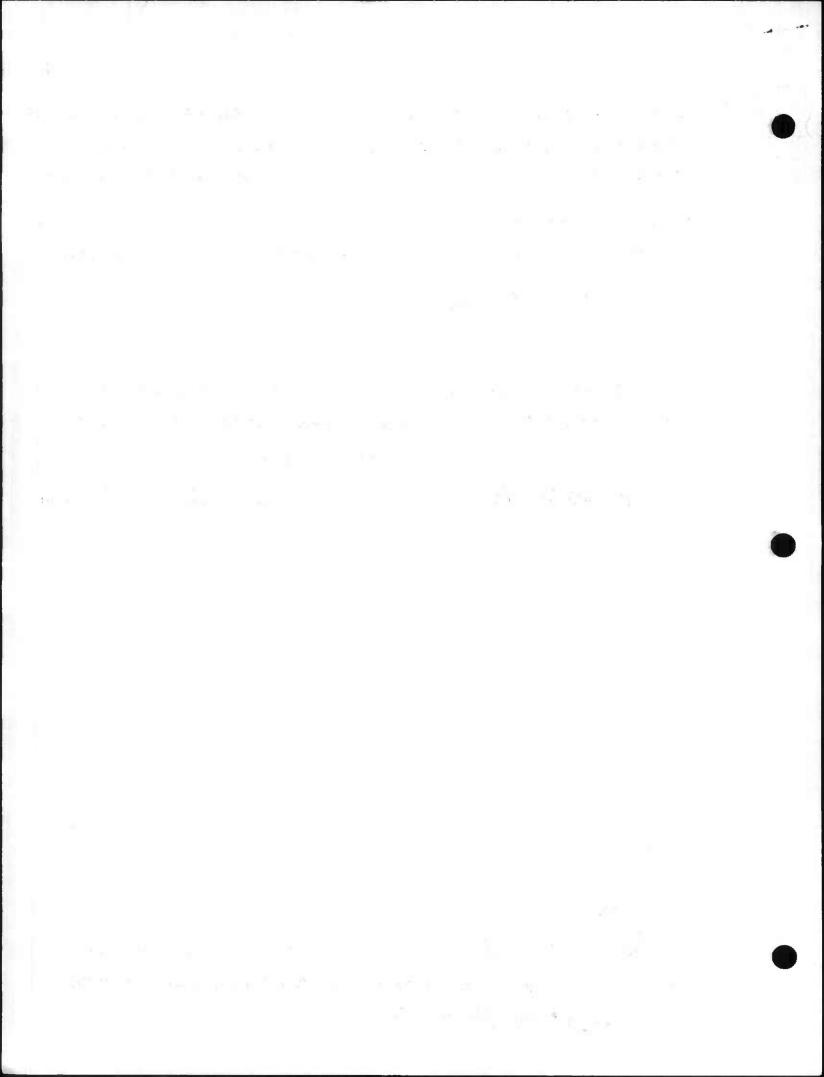
96 03584

| | | | | | | Cert | itica | te of | Death | | | Reg. No. | | | |
|-------------------|--|------------------|--|---|--------------------------|-------------------------------------|-----------------------------------|-------------------------|---|--------------------------|----------------------------|-----------------------------------|----------------------------------|--------------------------------|---|
| | Physic /Medi | | 1. Decedent's Neme (First, Middle, Li | MAE | PUL | Ley | | | | 2 | Date of De Month | eath Dev. | 96 | | A, m. |
| ? | Examir | | 4e. Fecility Neme (If not institution, gh | ve street and number) | | | | 4 | Bal | 1 | m d | h 4c. Count | | | |
| | Funeral Director | | | Sex 7. Age | _ | st birthday) Yrs. | If Unde Months | Deys | If Under 2 Hours | 4 Hrs. 8 Min. | Dete of Bir | th ay, Year) 20 - 14 | 9. Birthp Coun | lace (Sterry) | ete or Foreign |
| | Ba-f show | ector | 10e. Stete 10b. County M d N . A | | - | Town or Local | | | | | | | 1 | | le City Limits Yes 2 \(\subseteq No |
| | ath with the 23s or 2 | Funeral Director | 1537 ENSO | r 5t. | | | | 2 O | 2 | | | 10g. Citizen of $U - 5$. | | try? | |
| 0000 | n 72 hours after death with the Maryland "natural", or items 23s or 28s4 show redical Examiner must be notified at | þ | 11. Maritel Stetus 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes: | | lf ' | Yes, spe | dent of Hecify Cube | Ilspanic Orig en, Mexican, Specify: | in? (Speci Puerto Ric | ly Yes or No can, etc.) | Special | ce - Americ ck, White, by: | | 6 |
| 21215-0020 | S . | Completed | 15. Decedent's E (Specify only highest grant property) (0-12) | ducation ade completed) College (1-4or 5- | | 16a. Decede (Give ki life. Do | int's Usu ind of wi O NOT a | al Occup ork done | etion during most | of working | | 16b. Kind of E | | | 0. |
| Maryland | s should be filed within and Mental Hygiene. s marked other than aumatic event, the Mental than the Mental th | To Be C | 17. Fether's Neme (First, Middle, Last | ard | , | | 1 | | 18. Mother | 's Name (/ | First, Middle | Maiden Surnal | me) 150N | / | |
| | 1 and 2 should I Health and Men em 27 is marked | | 19e. Informent's Neme/Reletionship | Type, Print) | | 19b. Mailing 721 | ~ | | Ng hA | - | Route Numb | er, City or Town | | Code) | |
| altimore, | 00- | | 20e. Method of Disposition 1 | | 20b. Ple- cen | ce of Disposi netery, crems | itory or | other plea | iem Ph | | Dete 14/9L | 20c. Location | 1 2 | wn, Stet | е |
| Ball | pemit. Pag Department Important: It any Injury o | | 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Locks Funeral Home | | | | | | | | | | bents | al | ap |
| | Physician | | 23a. Rent1 Entar the disaasa, or com shook, or heert feilure. List only | plicetions thet causad one cause on each lin | the deeth. e. | Do not antar | the mo | de of dyln | g, such es c | ardlec or r | espiretory e | rrest, | | Approxi Interval Onset e | Imete Between and Death |
| | /Medical Examiner | | Immediata Cause (Finel disease or condition resulting in deeth) | · Metar | | es e conseque | | - 71 | and C | enc | ex | | | 4, | no |
| | cuted nd transit | Examiner | Sequentially list conditions, | b | | es a conseque | | | | | | | | | |
| ox 68760, | certificate be executed iding physician and ise as the bunal-transit | /Medical Ex | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initialed events resulting in deeth) Lest | c | ue to (or e | s e conseque | ence of): | | | | | | | | |
| . Bo | ath or u | iclan/ | Dort li Other significant conditions | | | tan talah aluma | la ch da c | | an la Band | | Ook Did | 4-1 | - | | |
| , P.O. | es that the death igned by the atter be detached for the | by Physician | Pert II. Other significant conditions of | |) | ing in the und | ariying | cause giv | en in Perti. | | | tobacco usa co Yes 2□ No | 3 Prot | | Unknown |
| of Vital Records, | aw requir | Completed b | 60 pk-40 smd | w | | | | | | | 24a. Wes | en eutopsy ormed? | eve | nileble pr | osy findings rior to of cause |
| al B | Page 1 | | 05.14 | | | | | | | | 10 | 7 | 10 |] Yas | 200 No |
| <u>S</u> | | o Be | 25. Wes case referred to medical examiner? | Hospitel: 1 ☐ Inpatier | 4 2 DE | R/Outpatient | 3 D | Oth Oth | O.F. | | Check only | one) dence 6 □Otl | or /Enacih | e) | |
| | Attending Physical Charles After this by the funeral d | | 27. Mannar of Deeth Volume 5 Pending 2 Accident Investigation | 28e. Dete of Injun (Month, Day | | 8b. Time of injury | | 28c. injun Wor | | 286 | | how injury occu | | <u>//</u> | |
| Division | al Directo | Certification: | 3 Sulcide 6 Could not be datemined | 28e. Plece of Injubulding, etc. | ry - At hom (Specify) | e, ferm, stree | ot, fector | y, office | | 281 | Location (City or To | Street and Num. wn, State) | ber or Rura | l Route l | Vumber, |
| 1 | | edical | 29e. Certifier (Check only one) IP Certifying Ph | ysician: To the best of ninar: On the basis of end menner stel | examinetlo | edge, daeth o n end/or inve | occurrad stigetion | at the tim , in my o | ne, dete end pinion, deeth | place, and occurred | d dua to the et the time, | ceuse(s) end m date end piece, | anner as st and due to | ated. the cau | se(s) |
| | With With Comp | × | 29b. Signeture end title of certifier | | | | 29 | c. License | e number | | | 29d. Dete signe | ed (Month, i | Day, Yes | ir) |
| | 1 | | | L mo | 10-12- | | | D3 | 330 | 7 | | 2/12 | 191 | P | |
| | | | 30. Name and address of person who | | | 3e) (Type, Pr | | - 54 | ACIT A | ST | Bn | 170 71 | 200 | | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32 Registre | | | ~ 1/ | | | - | 2-7 | J. 40 | | | |

| | | . t 1. Decedant's Nama (First, Middla, Las | .el | | | tificate of | | Mental Hy | Reg. No | 6 035 | |
|--|--|--|---|---|--|--|---|--|--|--|-------------------------|
| Physicia | n | | | | | | | 2. Data of De Month F | EB. Day | Year 3. Tima o | |
| /Medica Examine | | WILLIAM Frankli 4a. Facility Nama (If not Institution, give | n PE street and number | NCE, | JR. | | 4b. City, Town, o | FFRUA F or Location of Deat | | 996 1:4 | 1 PM |
| | | JOHNS HOPKINS/E | BAYVIEW | MEDI | CAL C | Γ. | BALTIM | | | N/A | |
| al | | 5. Social Security Number 6. Social Security Number 1 | 2X 7. A | ga (In yrs. 1 | last birthday) Yrs. | If Undar 1 Yaar Months Days | | in. (Month, Di | ay, Year) | 9. Birthpiaca (Stata Country) | |
| or . | | Usual Rasidance of Dacedant | | J+ | | | | NOV. 2 | 4, 1941 | Marylan | d |
| | _ | 10a. Stata 10b. County | | 10c. City | , Town or Loc | | | | | 10d. Insida C | |
| | Directo | Maryland Balt 10e. Street and Number | imore | | Full | erton 10f. Zip Coda | | | an Ohless of | | 2 No |
| 1 | | 4242 Slater Ave | nue | | | 100 | 36-2723 | | | What Country? nited State | 25 |
| | Funerai | 11. Maritai Status | 12. Was Decedant Armed Forcas | | S. 13. W | | | (Specify Yas or No arto Rican, atc.) | | ce - Amarican Indian, | - |
| 1 | y Fu | 1 Navar Married 2 Married | 1 Yas 2 | No Arr | ny 1 | Yas 2 X No | | arto Ficari, atc.) | | nck, Whita, atc. By: White | |
| 1 | ed by | 3 ☐ Widowed 4 ☐ Divorced | Yaar or Datas: | Korea | | ent's Usuai Occu | netion | | | Businass/Industry | |
| | Be Completed | (Specify only highast grade Elamantary/Secondary (0-12) | | 5+) | (Giva k | ind of work dona O NOT usa retire | during most of wed) | vorking | TOD. KING OF E | odomico amidustry | |
| | Con | 12 | | , | Meat | Cutter | | | | cery | |
| | | 17. Fathar'a Nama (First, Middla, Last) William Frankl | in Donco | C m | | | | lama (First, Middla erine Ma | | | |
| 1 | ို | WIIIIdili FFdIKI 19a. informant's Name/Ralationship (7 | | , JI. | 19b. Mailing | Addraas (Strea | | | | n, Steta, Zip Coda) | |
| | | Mary Ann Pence (W | life) | | | | | ltimore, | | | |
| | | 20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ | Ramoval from State | C | ematary, crem | ition (Nama of atory or other pla | ice) | Date | | - City or Town, Stata | |
| | - | 4 Donation 5 Othar (Spacify |) | Emr | | | em. 2/14 | /96 | Balto. 1 | Md. | |
| | | 21. Signatura of Funaral Sarvice Licens | 7. Gnin | _ | 22. | Nama and Addra | L | eonard J | , | | 045: |
| | | 23a. Part1. Entar tha disaase, or comp | ication that cause | d tha daath | . Do not anta | r tha moda of dyl | | | | Balto. Md | ta |
| ian | ì | shock, or haart failura. List only o | ona causa on aach i | ina. | | | | | | intarvai Be Onsat and | tween Death |
| cal ner | | Immediata Cause (Final disaasa or condition resulting in daath) | . ATHOROS | CLOM | MICED | av oign | Sumphy | 2180036 | | | |
| ш. | - 1 | | | Dua to (o | es e consequ | anca of): | | | | | |
| | e | | | | | | | | | 1 | |
| | aminer | Sequentially list conditions. | b | Due to (or | as a consequ | ance of): | | | | 1 | |
| 14.5 | ai Examiner | Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Diseasa or inlury | b | Due to (or | as a consequ | ance of): | | | | | |
| 11.7 | | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last | b | , | as a consequ | | | | | | |
| 11.7 | | If any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events | b | , | | | | | | | |
| 4.5 | | If any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events | bd. | Dua to (or | as a consaqu | ance of): | van in Part I. | 23b. Did | tobacco usa co | ontribute to the cause | of death? |
| Director Annual Line | Physician/Medicai | if any, leading to immadiata cause. Entar Undaryling Cause (Diseasa or injury that initiated events rasulting in death) Last | bdntributing to death b | Dua to (or | as a consaqu | ance of): | van in Part I. | | tobacco uea co | | of death? |
| has Disselve to the Alexand | by Physician/Medical | if any, leading to immadiata cause. Entar Undaryling Cause (Diseasa or injury that initiated events rasulting in death) Last | bd | Dua to (or | as a consaqu | ance of): | van in Part i. | - 10 | Yee 2□ No | 3 Probably 4 € | Onknown |
| has Disselve to the Alexand | by Physician/Medical | if any, leading to immadiata cause. Entar Undaryling Cause (Diseasa or injury that initiated events rasulting in death) Last | b | Dua to (or | as a consaqu | ance of): | van in Part I. | 1 🗆 24a. Was | Yee 2 No s an autopsy ormed? | 3 Probably 4 24b. Wara autopsy available prior completion of | findings to |
| has Division of the Allers | by Physician/Medical | if any, leading to immadiata cause. Entar Undaryling Cause (Diseasa or injury that initiated events rasulting in death) Last | bd | Dua to (or | as a consaqu | ance of): | van in Part i. | 24a. Was perf | Yee 2□No s an autopsy ormed? | 3 Probably 4 \(\) 24b. Ware autopsy available prior completion of oil death? | findings to causa |
| Commission In Division Annual | Completed by Physician/Medical | If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions co | b | Dua to (or | as a consaqu | ance of): | | 24a. Was perf | Yee 2□ No s an autopsy ormed? A Pour Yas 2 □ No | 3 Probably 4 \(\) 24b. Wara autopsy available prior completion of of death? | findings to |
| To Do Commission in the Commission of the Commis | to be completed by Physician/Medical | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Part ii. Other algnificant conditions co | Hospitai: 1 ∐ Inpati | Dua to (or put not rasu | as a consaqu | ance of): darfying causa gr | 26. Piaca of D har: 4 ☐ Nursing | 24a. Was peri | Yee 2 No s an autopsy ormed? A Pour Yas 2 No ona) idance 8 101 | 3 Probably 4 2 24b. Ware autopsy available prior completion of death? 1 Pres 2 | findings to causa |
| T. D. C. L. L. L. L. L. L. L. L. L. L. L. L. L. | to be completed by Physician/Medical | If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions co | Hospital: | Dua to (or put not rasu | as a consaqu | ance of): darlying causa gi | 26. Placa of D har: 4□ Nursing iny at ink? | 24a. Was peri | Yee 2 No s an autopsy ormed? A Pour Yas 2 PNo ona) | 3 Probably 4 2 24b. Ware autopsy available prior completion of death? 1 Pres 2 | findings to causa |
| To Do Commission in the Commission of the Commis | to be completed by Physician/Medical | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Part ii. Other significant conditions co 25. Wes case referred to medical examinar? 1 X Yes 2 No 27. Manner of Deeth 1 Natural 5 Panding investigation 3 Suicide 6 Could not be | Hospitai: 1 ∐ Inpati 28a. Data of inju (Month, Da | Dua to (or but not rasulting the first XIX bury year) | as a consaquiliting In the und | ance of): darlying causa gi 3 DOA Ott 28c. Inju Wo 1 | 26. Placa of D har: 4 ☐ Nursing ry at rk?] Yas 2 ☐ No | 24a. Was perful and the control of t | Yee 2 No s an autopsy ormed? Yes 2 No one) idence 8 Oth how injury occu | 3 Probably 4 2 24b. Ware autopsy available prior completion of death? 1 Pres 2 | findings to causa |
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| Total Control of the | Certification: 10 be Completed by Physician/Medical | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions c | Hospitai: 1 ☐ inpati 28a. Data of inju (Month, Da 28a. Piace of in building, at | Dua to (or but not rasularly say Year) jury - At hoto. (Specify of my know show show show show show show show sh | as a consaqu liting In the und EF/Outpatient 28b. Time of injury ma, farm, stre- | ance of): darlying causa gi a DOA Ott 28c. Inju Wo 1 = 1, factory, office | 26. Place of D har: 4 Nursing ry at rk? Yas 2 No | 24a. Was performed and the second of the sec | Yee 2 No s an autopsy ormed? Yas 2 No ona) idance 8 Ott how injury occu (Straat end Num wn, Stata) | 3 Probably 4 1 24b. Wara autopsy available prior completion of of daeth? 1 Pres 2 2 hear (Specify) rred | findings to causa |
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| included Considering To Do Commission Inc. Discounted in the Constant of the C | edical certification: 10 Be Completed by Physician/Medical | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Part ii. Other significant conditions could be conditioned to the conditions of the | Hospital: 1 inpati 28a. Data of injumonth, Da 28a. Piace of in building, al eician: To tha best iner: On tha basis of and manner st | Dua to (or but not rasulated. | as a consequence of the conseque | ance of): darlying causa given and a control of the control of th | 26. Place of Dhar: 4□ Nursing at rk? 3 Yas 2□ No ma, data and pia opinion, daath ocus a number . M.E. | 24a. Was performed at the time, | s an autopsy ormed? Yas 2 1 No ona) idance 8 1 Ott how injury occu (Straat end Num wn, Stata) causa(s) and m data and placa, 29d. Data signer | 3 Probably 4 1 24b. Wars autopsy available prior completion of of daath? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | findings to causa |
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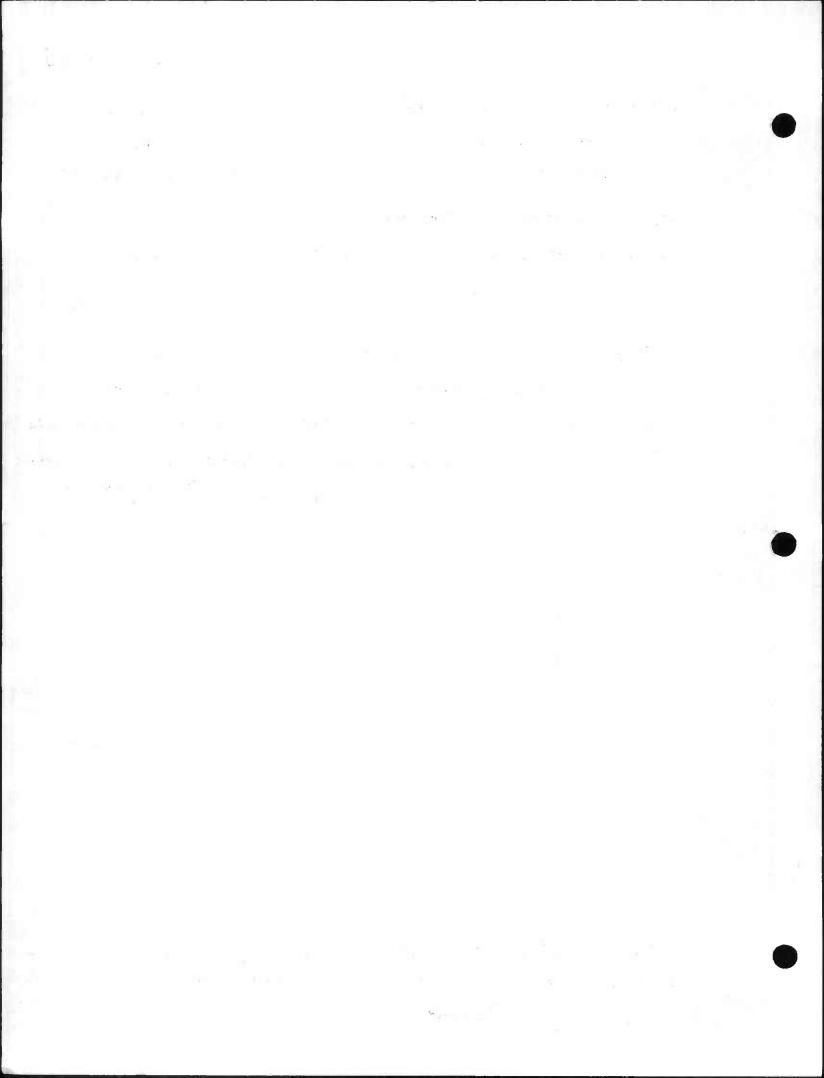
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State of Maryland / Department of Health and Mental Hygiene 96 03586

| | | | | | | Cert | ificate of | Death | | Reg. Nc | 0 | 00000 | |
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| | Examir | | 4a. Facility Name (If not institution, given North Arundel | | | | | | n, or Location of Dea Burnie | | y of Death | ndel | |
| | Funeral Director | | 213 24 3490 | Sex 7. Age (| In yrs. last birt | thday) Yrs. | If Under 1 Year Months Days | If Under 24 Hours | Hrs. 8. Data of B Min. (Month, C Jan • | irth 20, Year) 16, 1930 | Coun | olaca (State or Foraign oldy) Yland | |
| 7 | Maryland | ctor | Usual Rasidanca of Decedant 10e. Stata 10b. County Maryland Anne Ar | | oc. City, Towr Pasad | | ation | | | | 1 | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No | |
| | th with the | al Director | 10e. Street and Number 8028 Abbey Court | t Apt. E | | | 10f. Zip Code 211: | 22 | | 10g. Citizan of | | ntry? | |
| 21215-0020 | 72 hours after deeth with the Maryland naturel', or items 23s or 28s-f show dical Examiner must be notified at | by Funeral | 11. Marital Status 1 Navar Marriad 2 X Married 3 Widowed 4 Divorced | 12. Was Decedent Even Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: | er in U,S. | | as Decedant of I Yes, specify Cub | | n? (Specity Yes or N Puarto Rican, atc.) | lo- 14. Ra Bis | ca - Amaric ack, White, fy: W | | |
| 15-0 | d within 72 hours jiene. r than "naturel", fre Medical Exc | Completed | 15. Decedent's Ed (Specify only highast gra | ducation ada completed) | 16a. | Decede (Giva ki | nt's Usuai Occu ind of work dona O NOT usa retire | pation during most o | of working | 16b. Kind of E | usiness/in | dustry | |
| 121 | | du | Elementary/Secondary (0-12) | Coilega (1-4or 5+) | | | ONOT usa retire Driver | nd) | | M.T. | 7 | | |
| | be filed tel Hygid d other event, t | Be Co | 12th 17. Fathar's Nama (First, Middla, Last, |) | | Dus | DIIVEL | 18. Mothar's | Name (First, Middle | | | | - |
| /lar | | To B | P | Albert Roter | n Parks | 5 | | | Mary Cec | elia Scl | mehl: | ing | |
| Maryland | 2 sho | | 19a. informant's Name/Raiationship (| | | _ | | | or Rural Routa Num | | | | |
| | Heal Heal Heal ther | | Isabell M. Parks 20a. Mathod of Disposition | | 20b. Piace of | Disposi | tion (Nama of | | Data Pas | 20c. Location | | and 21122 | _ |
| Baltimore, | Peges nent of ant: If it | | 1 St Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification) | Ramoval from Stata | cematar | y, crama Have | n Memor | ial Par | 2000 | | | e, Marylan | d |
| Ba | Departr Departr Imports any inje | | 21. Signature of Funeral Service Licer |) . | la) | | Nama and Addr Ol Ritcl | | Gonce jhway Bal | Funeral timore, | | | |
| | | | 23a. Part1. Entar tha disease or equi- shock, or heart failura. Vist prily | plications that caused th ona causa on each ilna. | a daath. Do n | not antar | tha moda of dyl | ng, such as ca | ardiac or raspiratory | arrest, | 1 | Approximata fntarvai Batween Onset and Death | |
| 7 | Physician /Medical Examiner | Н | immediata Causa (Finai disaasa or condition rasulting in death) | a ACUTA | MY | oc) | AN DIAZ | - F | VFANCIN | DN . | 1 | 1074 | |
| | | ner | Table 11 and 11 | b. COLON | a to (or as a c | conseque | anca of): | AIC | PAGE | | | 7 URANI | C |
| ó | icate be executed physician and s the buriel-fransit | Examiner | Sequantially list conditions, if any, leading to Immediata causa. Entar Underlying Cause (Diseasa or injury | | a to (or as a c | conseque | | | YONARY | DUCA | æ | TYPAN | 5 |
| Box 68760, | 200 | n/Medical | Cause (Diseasa or injury that initiated events resulting in death) Last | d | a to (or as a c | | | | | 1) 0 () | | J /(///9 | |
| P.O. B | that the death ce ned by the ettend | Physician/ | Part ii. Other significant conditione c | ontributing to death but r | not rasuiting in | tha und | terlying causa gl | ven in Part f. | | 23b. Did tobecco use contribute to the cause of death | | | |
| Records, | requires been sign should be | Completed by | | | | | | | 24a. Wa | s an autopsy formed? | av | ara autopsy findings allable prior to impletion of causa | |
| Re | hes hes | ошо | | | | | | | 10 | Yes 2 No | | daath? ☐ Yas 2☐No | |
| Vital | | Be C | 25. Was casa raferred to medical axaminer? | | | | | 26. Placa o | f Death (Check only | | | | |
| of V | Physicien: this certific ral director, | ² | 1 ☐ Yas 2 ☐ No | Hospitai: | 2 ER/Out | | 3LI DON | | ing Homa 5 Ras | | | y) | |
| ivision | E 5 5 | Certification: | 27. Manner of Death Maturai | | (ear) 28b. T | ime of njury | 28c. Inju Wo | nyat ork?]Yas 2 ☐ No | | how injury occu | rred | | |
| ğ | ta rs after d al Direct led in by | | 3 ☐ Sulcide 4 ☐ Homlcida 6 ☐ Could not be datarmined | 28a. Placa of Injury building, atc. (| - At homa, fai Specify) | rm, strae | at, factory, office | | | (Street and Num own, Stata) | ber or Rura | Il Routa Number, | |
| | To the Hospital of Amendi within 24 hours after death. To the Funeral Director: A completaly filled in by the fi | edical | (Check only 2 Medical Examone) | ysician: To the best of miner: On the besis of ax and manner state | amination and | , daath o | occurred at tha ti stigation, in my | ma, data and opinion, daath | piace, and dua to the occurred at tha time | a cause(s) and m | annar as s , and dua to | tated. o tha cause(s) | |
| | To t | Σ | 29b. Signature and titia of certifier | 1. 11.1 | 1.1 | 7 | 29c. Lican | | , | 29d. Data sign | | / | |
| | ν | | 11-14-50 | mely de | , M | /_ | 02 | 82 | 21 | tebua | ny 1 | 4/17/6 | |
| _ | 0 | | 30. Nama and addrass of person who | complated cause of daal | th (item 23a) (| Type, P | rint) HOSPITA | z DI | WE GLE | U bus | viE. | 12,1996 Mayer | 2 |
| | Sta Registr | | 31. Bata filed (Month, Day, Year) FEB 1 3 1996 | 32. Registrar | Signatura | | | | | | | 2106 | (|



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State of Maryland / Department of Health and Mental Hygiene

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| Exami | | 4a. Facility Neme | | giva street end no ital Cent | | | | 46. City, Town, or L Randalls | | | of Death timor | 0 |
| Funerai Director | П | 5. Societ Security I | Number 707 | 6. Sex 1 □ M 2 🂢 F | 7. Aga (In yrs. 63 | . last birthdey) Yrs. | If Undar 1 Yaar Months Days | If Undar 24 Hrs. Hours Min. | | th y, Year) 20, 1932 | 9. Birthp | elece (Stata or Foreigntry) USYLVANÍA |
| aryland show | | 10e. Stete | 10b. County | | 10c. Ci | ity, Town or Loc | | | | | 1 | 0d. Inside City Limit |
| No Maria | cto | Md. | Balt | more | | Reis. | terstown | | | | | 1 ☐ Yes 2 ☐XN |
| ith with the Marylan 23e or 28e-f show ust be notified at | Director | 10e. Street and Nu | | 1 | | | 10f. Zip Code | 12/ | | 10g. Citizen of N | | ntry? |
| eath re 23 | eral | 11. Maritai Status | urch Rod | | edant Ever in U | 10 10 10 | | 136 | | | SA | an Indian |
| filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or terms 23a or 28a-f show Int, the Medical Examiner must be notified at | by Funeral | | ried 2 Merrie | Armed F | orces? 2 🔯 No ive | If | Yes, specify Cubi | lispanic Origin? (Sp an, Mexican, Puarto Specify: | Rican, etc.) | | ce - Americ ck, White, y: Whi | etc. |
| 72 hour | Pel | | 15. Decedent's | Education | | 16e. Deced | ent's Usuel Occup | ation | | 16b. Kind of B | _ | |
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| | | 1. DECEDENT'S NAME (FIRST, Edward Jose | | korny | | | | | | | 2. DATE OF | DAY | | YEAR | 3. TIME OF DEATH |
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| Z15-00Z0 attending physician. se as the burial-transit | BY FU | 11. MARITAL STATUS 1 X Never Merried 2 3 Widowed 4 Divo | | 12. WAS DECEDEN' FORCES? 1 IF YES, GIVE W | YES | 2 X NO | | If yee, ap | ENDENT O | n, Mexican | C ORIGIN? (S , Puerto Rica | pecify Yes (n, atc.) | or No— | 14. RACE Black Speci | - American Indian, t, White, etc. |
| r attend | ED | 15. DEC | EDENT'S EDU y highest grade | CATION completed | T | 16a. DECEDENT'S (Give kind of | USUAL O | CCUPATIO | ON | | 16b, KII | ID OF BUSI | NESS/IND | USTRY | MITCE |
| N B E | Ē | Elementary/Secondary (0 | | College (1-4 or 5 + |) | life. Do NOT u | se retired.) | auring mo | ist or worten | g | | | | | |
| he hospital detached for | COMPL | 8 17. FATHER'S NAME (First, MI | iddle, Last) | | | Clerk | - | | 18 MOTE | IED'S NAM | Cit | | | Dep | artment |
| # 8 A | l w l | Joseph | | | P | okorny | | | | tonia | | e, welden s | ornemaj | Lav | icka |
| maky retained by 5 should b | 0 B | 19a. INFORMANT'S NAME (7) | | | | 19b. MAILING | | | | | | | | Code) | |
| | | Mary Jean S | | field | | | | | , Tov | wson, | | | | | |
| LEU W | | 1 N Burial 2 Crematio 4 Donation 5 Other | n 3 🗆 Rem | oval from State | cemet MOS | PLACE AND DATE | ther place) | eemei | r Cen | eter | v2/14 | Ra 1 | timo | Aty or To | Maryland |
| ALLIMO death. Page 6 s funeral directo f. | | 21. SIGNATURE OF FUNERAL | L SERVICE LIC | CENTEL | > | | 22. | NAME AN | ND ADDRES | S OF FACI | ILITY | | | | TRILYTAIRI |
| | | tohe | 79 | tal | | | | | | | defelo | | | | yland 2121 |
| be executed within 24 hours clan and completely filled in 1 for to burial, cremation, or re-raumatic event, the med | CERTIFICATION | 23. PART I Enter the dishock, or hat shock, or hat immediate (fin disease or condition resulting in dasth) Sequentially list conditi if any, leading to immediates. Enter UNDERLY! CAUSE (Disease or injustat initiated events | ions, diata | a. Property one cause of the control | OR AS A C | CONSEQUENCE O | 13 | fee eu | 15 | ng, auch | as cardiac | Tuli | e u | l l | Approximata Interval Betwee Onset and Dea |
| FIGURE OF VITAL TECONIOS, F.O. DO READING PHYSICIAN: The law requires that the death certificate READING THE Cate to be signed by the attending physical rem death with the State Dept. of Health and Mental Hygiene or Is marked, or Item 23 shows any Injury, or other the | MEDICAL | PART II. Other algnification | nt condition | lia | | | | | | | _ +(| . WAS AN A PERFORM | EO? | 24b. | WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| N: The law scate has State Dept Mem 23 | SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | | HOSPITAL: | | . PLACE OF DEA | TH (Check | only one) | 0110 | EICI AUI (| | | | | |
| SICIAN: The Certificate I the State I, or Item | IXSI | 1 TYES 2 NO | | 1 Inpetient 2 | | | | aing Hom | | | Other (Sp | | | | |
| PHYS this with | Y PHY | 1 Natural 5 🗌 I | Pending | (Month, Da | | 28b. TIM | URY | | URY AT RK7 (ES 2 | - 1 | 28d. DESCRI | BE HOW IN. | JURY OCC | URED | |
| | ETED BY | 3 Sulcide s | restigation Could not be determined | 28e. PLACE Of building, (| F INJURY — etc. (Specify | - At home, ferm, | street, fact | | | - | 281. LOCATIO City or To | N (Street en wn, Stete) | d Number o | or Aurel A | oute Number, |
| 選出の単 | COMPLE | | | CIAN: To the best of ex | | | | | | | | | | | and manner ee stated. |
| F = # 8 | BE C | 29b. SIGNATURE AND TITLE | OF CERTIFIER | V | A A | 0110 | 1.00 | ~/ | | NSE NUMB | | | 29d. DATE | SIGNED | (Month, Day, Yber) |
| TO THE De filed IMPOR | 10 | 30. NAME AND ADDRESS OF | N BEREON WAY | O COMPLETED COMP | | Fue | cu | | D-3 | 30661 | | | ▶ F | EB. | 12, 1996 |
| | | Sireesh K. | | | | | | ΛΊοι | moda | Po 1 | timor | o Mo | | n | 1120 |
| | | 31. DATE FILED (Month, Day, | thar) | 32. REGISTRAF | R'S SIGNAT | TURE | LIIC | TILCI | neda, | Dal | CIMOL | ria. | цута | na z | .1239 |
| | | FEB 1 3 19 | 96 1 | 1. divile | Red | H | | | | | | | | | |
| | | | 0 | | | | | | | | | | | | DHMH-16 Rev |
| | | | | 10 | | | | | | | | | | | |

in Alexander

IOd. INSIDE CITY I TES 2 NO

BE COMPLETED BY FUNERAL DIRECTOR

0

MEDICAL CERTIFICATION

PHYSICIAN:

ВҰ

COMPLETED

8 2

27. MANNER OF DEATH

1 X Natural

2 Accident

3 Sulcide

4 Homicide

Manuel V.

| | | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have been of the page 1, 2, 3 should have been of the page 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be considered by the attention of the page 2, 2, 3 should be considered by the attention of the page 3, 2, 3 should be considered by the attention of the page 3, 2, 3 should be considered by the attention of the page 3, 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, | | |
|----------------|---|---|---|---|
| | | 1, 2, | | |
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| 3 | or att | or use | | |
| 2 | Spital | hed fo | at | |
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| | Pa Da | ad bi | od at | |
| | retaine | 5 shoe | otiffe | |
| ĵ | ay be | page | be n | |
| 5 | . 6 m | ector, | must | |
| 200 | Page. | ral din | iner | l |
| 200-C1312-0050 | death | e fune | ехэп | |
| 3 | rs after | n by th | dicai | Ī |
| | 4 hou | filled in | e me | |
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| | ate be | hysicia Drior | r ta | |
|) | certific | ding pi | othe | |
| - | death | attendatte | ry, or | |
| | t the | by the | ului / | |
| | es tha | gned ealth a | s am | ŀ |
| 1 | requi | of H | show | |
| | R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | is certificate has been signed by the attending physician and completely filled in by the first the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| | JAN: T | rtificate | or ite | |
|) | HYSIC | his cer | ked, | |
| | NING P | After t | шаг | |
| | TTENC | after o | 28 is | |
| | OR A | DIREC | Hem | |
| | PITAL | MINERAL DIRECTOR: After this with 72 hours after death with | T: H | |
| | E HO | 3 | HTAN | |
| 1 | 1 DL | 100 | MPO | |

| 1 - STATE STATE (| F MARYLAND | / DEPAR | RTMENT | OF H | EALTH AND I | | YGIENE | | | |
|---|----------------------------|-----------------------|--------------|----------------|---|------------------|---------------|------------|----------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | DEATH | 2. DATE OF D | EATH | | | 3. TIME OF DEATH |
| Edith Lipscomb Qui | gley | | | | | Feb. | 9. DAY | 1996 | YEAR | 5:50 |
| 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. | | IF UNDER | 1 YEAR DAYS | IF UNDER 24 HRS. | 7. DATE OF B | (RTH (bar) | | 8. BIRTH | HPLACE (State or Form |
| 214-40-5439 I - M 2 D | ~ /- | YRS. | | | | Dec. | 12, 1 | 904 | Ma | ryland |
| 90. FACILITY NAME (N not institution, give street and number Meridian Multi-Medical | v) | | | | OR LOCATION OF DE | EATH | - 1 | 9c. COUN | | |
| RESIDENCE OF DECEDENT | | | Tows | on | | | | Ba | Lt1 | more |
| 10e. STATE 10b. COUNTY | | IOc. CIT | TY, TOWN O | R LOCAT | ION | | | | | IOd. INSIDE CITY |
| Maryland Baltimore | | Ba | ltimo | re | | | | | | I YES 2 N |
| 100. STREET AND NUMBER | | | | 101 | . ZIP CODE | | T | | | WHAT COUNTRY? |
| 127 A. Dumbarton Road | | | | | 21212 | | | - | .S. | Α. |
| 1 Never Married 2 1 Merried FORCES? | EDENT EVER IN U.S. I YES 2 | ARMED X NO | - 10 | yes, sp | ENDENT OF HISPAN ecity Cuben, Mexice 2 NO Specifi | n, Puerto Rican. | ecify Yee o | or No- | | E — American Indian k, White, atc. White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | DECEDENT'S | work done di | CUPATIO | ON st of working | 16b. KINI | OF BUSH | NESS/INDI | JSTRY | |
| Elementery/Secondary (0-12) College (1-4 12 years | or 5+) | ii. Do NOT u Teach | se retired.) | | | Del | .1 | F3 | | |
| 17. FATHER'S NAME (First, Middle, Lest) | | reach | er | | | | olic | | atio | on |
| Archibald Jerone Lipsco | omb | | | | Edith | | | | b | |
| 19e. INFORMANT'S NAME (Type/Print) | | | | | nd Number or Rural I | Poute Number, Ci | ity or Town, | State, Zip | Code) | |
| Janice A. Moore | | 5504 | Spri | ngl: | ake Way, | Baltin | nore, | MD | 212 | 12 |
| 20a. METHOD OF DISPOSITION 1 Buriel 2 D Cremetion 3 Removal from Stal | 20b. PLAC | CE AND DATE | OF DISPOSI | TION (Na | ory Feb | DATE | 20c. LOC/ | | | Maryland |
| 4 Donetion 5 Other (Specify) | 010100 | - TIMO CII. | | | | | | | | ratytand |
| | () | | | | nell-Wie | | | | | |
| hours (posego) |)OUT | | | | York Rd | | | | | |
| 23. PART I. Enter the disease, or complication, ahock, or heart failure. List only one IMMEDIATE CAUSE (Finel | cause on Each II | Ine. | not enter t | the mo | de of dying, auc | h aa cerdlac (| or reapira | itory arre | eat, | Approximat interval Bet Onset and |
| disease or condition | 1515 | | | | | | | | | 3 DA |
| Sequentially list conditions, | IN AP- | SEQUENCE O | PA | et | - 1N | FECT | 70 | N | | 3 DAG |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | L TO (ON AS A CON | SECUENCE O | r.). | | | | | | | |
| that initiated events resulting in death) LAST | E TO (OR AS A CONS | SEQUENCE O | F): | | | | | | | |

PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. PMBNTA

24a. WAS AN AUTOPSY PERFORMED? I TYES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? I YES 2 NO

Approximate interval Between Onset and Death 3 DAUS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO [

25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 XO

1 Inpatient 2 ER/Outpatient 3 DOA ne 5 🗆 Reside

28e. DATE OF INJURY 28b. TIME OF INJURY 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, stc. (Soecity)

6 Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

281. LOCATION (Street end Number or Rural Route Number City or Town, Stete)

29e. CERTIFIER (Check only one) 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

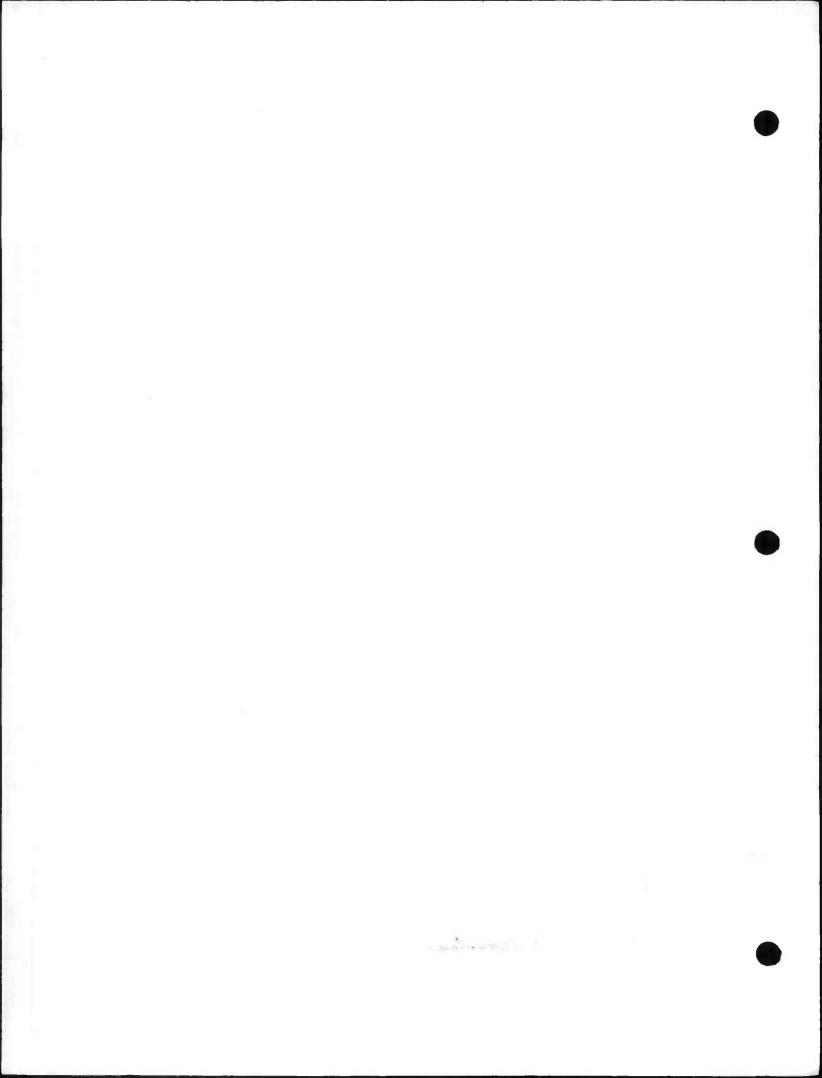
6800 York Rd. Baltimore, MD 21212 M.D.

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE FEB1 3 1996

Ramos

Investigation

8 Could not be determined



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| after | to A | THON | 163 |
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| - N | peel | f. 0 | Sh |
| TO THE PHYAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | In the FLINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | be fired within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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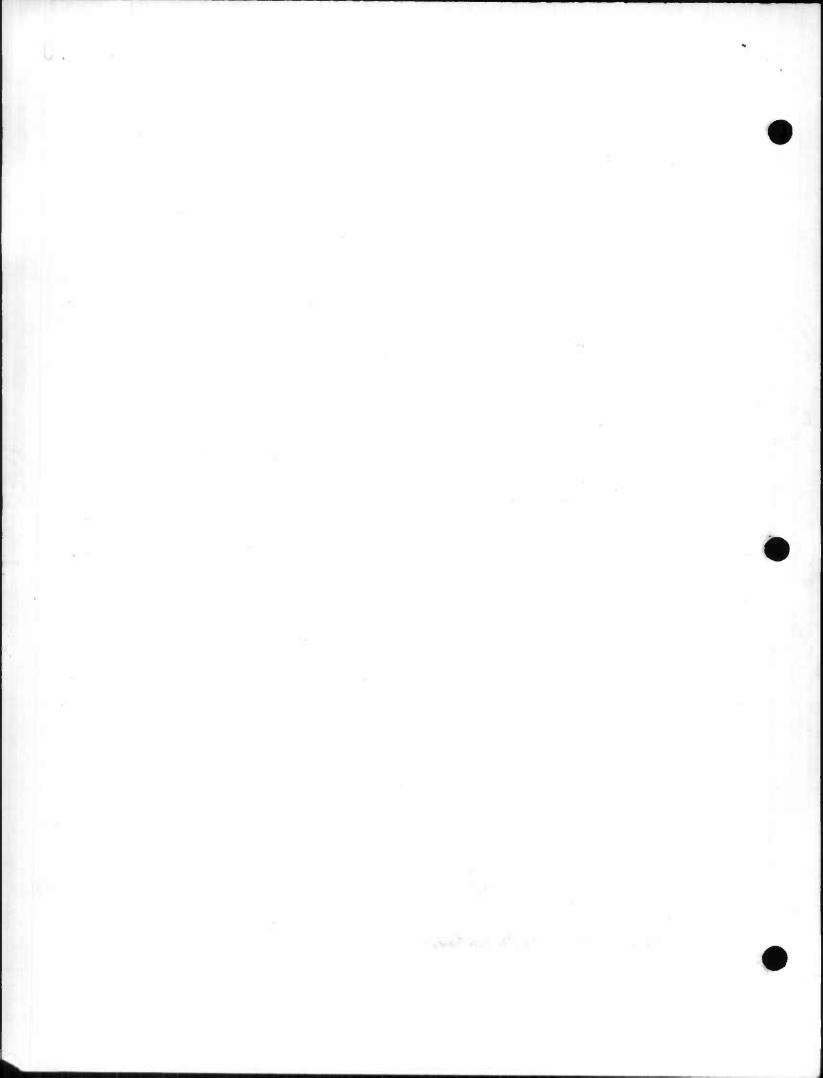
| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | AND / DEPAR | ITMENT OF I | HEALTH AND | MENTAL | HYGIENE REG. NO. | | | 19 63 | | |
|---------------|--|---|------------------|-----------------------------|--|---------------------------------|------------------------------------|-----------|-------------------------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) TOSE DA E 4. SOCIAL SECURITY NUMBER | | EKU | | | Fe | | 190 | | 3. TIME OF DEATH 2.06 PM | | |
| | 195-10-9877 | 1 X M 2 □ F 80 |) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. | July | 7 29,19 | 915 1 | Peni | nsylvania | | |
| TOR | Howard County Gene | | | Columb | ia | EATH | | HOT | | | | |
| DIRECTOR | Maryland Howa | | Y, TOWN OR LOCA | | | | | | 10d. INSIDE CITY LIMITS? t YES 2 NO | | | |
| FUNERAL | 7395 Hopkins Way | | | 10 | 21029 | | | USA | | WHAT COUNTRY? | | |
| ВУ | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, s | CENDENT OF HISPA pecify Cuben, Mexic 8 2XXNO Speci | an, Puerto I | | or No — 1 | Black | E — American Indien, k, White, etc. In: White | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 +) | | | | 16b. | Restau | | STRY | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) Joseph Rekus | | | | 18. MOTHER'S NA Eva R | ewt | Aiddle, Meiden S | Surneme) | | | | |
| 101 | 199. INFORMANT'S NAME (Type/Print) Richard R. Rekus 7395 Hopkins Way, Clarksville, Maryland 21029 200. METHOD OF DISPOSITION 15 Burlal 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Specify) 20c. DOTATE OF Town, State 20c. LOCATION — City or Town, State 20c. DATE 20c. LOCATION — City or Town, State 20c. Date (Specify) Town, State 20c. Date (Specify) Town, State 20c. Date (Specify) Town, State 20c. Date (Specify) Town, State 20c. LOCATION — City or Town, State 20c. LO | | | | | | | | | | | |
| | 23. PART / Enter the diseases, or ahock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | Emplication List only one ceuse on a | i ve death. Do | Flector 7601 | k Funera Sandy S | ACILITY 1 Honoring ch as care | ne, Inc | Law | cel. | MD 20707 Approximate Interval Batweer Onset and Deatl | | |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | CONSEQUENCE C | | | | | | | | | |
| MEDICAL C | PART II. Other algoriticant condition Hypertension | one contributing to deeth b | | | | n Pert I. | 24a. WAS AN A PERFORM | MEO? | 248 | D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 N NO | | |
| PHYSICIAN: 1 | DID TOBACCO USE CONTI | HOSPITAL: | 26. PLACE OF DEA | OTHER: |) | | | | | | | |
| BY PHYS | 27. MANNER OF OEATH 1 Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. Til | WE OF 28c. II | me 5 Residence | V | CRIBE HOW IF | NJURY OCC | JRED | | | |
| ED | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, atc. (Spec | At home, farm, | street, factory, off | Ice | 2at, LOC City | ATION (Street e or Town, Stete) | N / | Rural | Route Number, | | |
| COMPLET | CONDUCTORINY | ICIAN: To the best of my know IR: On the basic of examination | | | | | | | | s) and manner ee stated, | | |
| TO BE | 290, SIGNATURE AND STORE OF CERTIFICATION OF THE SAME AND ADDRESS OF PRISON WITH | Mn COMPLETED CAUSE OF DE | SATM STEM OF ST | - Original | 29c. LICENSE NO. | | 9 | P / | ek. | (Month, Day, Year) | | |

2 Knoll N. DV.

OHMH-16 Rev 1/89

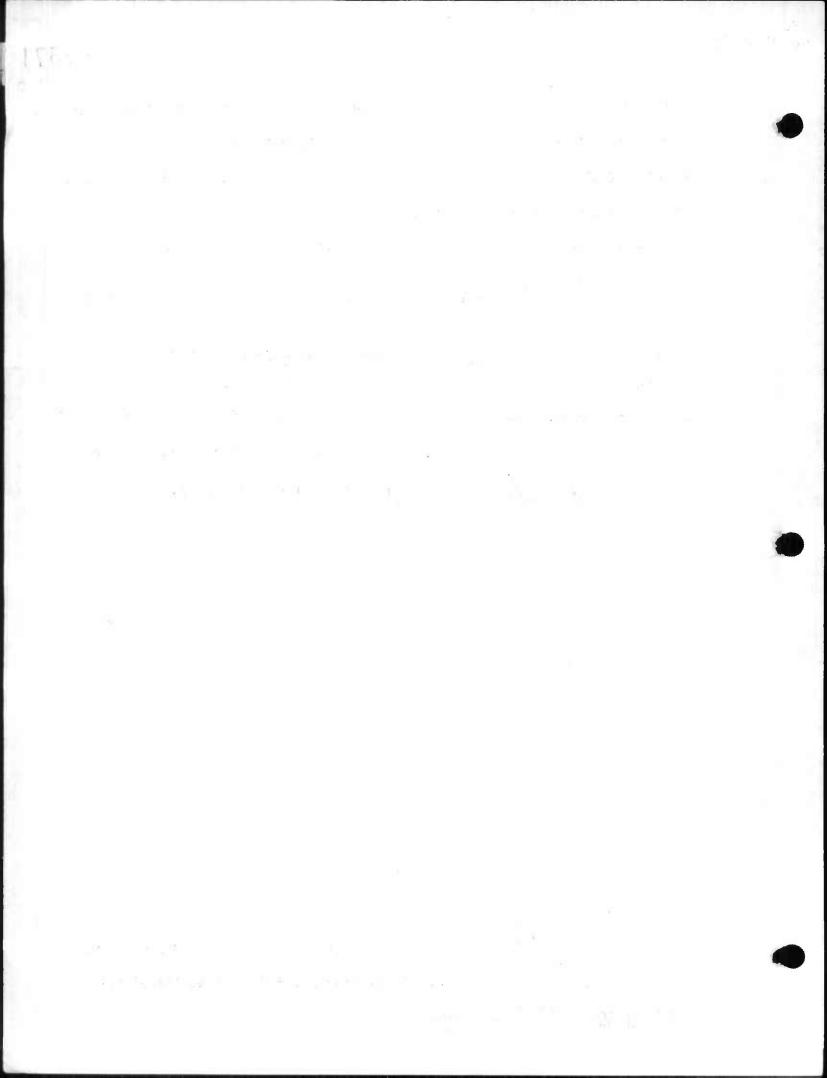
21045

Allen Funk 31. DATE FILED (Moritin, Day, Year) FEB 1, 3 1996



State of Maryland / Department of Health and Mental Hygiene

| | TTFN #19 | a f | ilm g732 2/14/96 ag | | | Certifical | te of | Death | F | leg. Nu | 90 | 03391 | |
|------------|--|------------------|---|---|--------------------------------|---|--------------------------|---|-----------------------------------|-----------------------------|------------------|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Las | st) | | | | | 2. Date of Dea Month | th Day | Yeer | 3. Time of Death | |
| | /Medic | | WINFRED | Α. | | RC | SS | | FEB. | 06, 19 | | 4:07 PM | |
| | Examir | | 4e. Facility Neme (If not institution, give | e street end number) | | | | 4b. City, Town, or L | ocation of Deeth | 4c. County | of Deeth | | |
| | | | SHOCK TRAUM | IA | | | | BALTIM | ORE | | | | |
| | Funeral | | Social Security Number 6. S | | yrs. last bir | thday) If Unde Months | r 1 Yeer Days | | 8. Date of Birth (Month, Day | Year | 9. Birthp | place (State or Foreign | |
| | Director | | 577-50-9632 | ^{2 M 2 □ F} 82 | | Jul. 8, 1913 Minneso | | | | | | | |
| | 2 . | | Usuel Residence of Decedent | 140 | 01. 7 | | | | | | | | |
| | e Marylar Sa-f ehow | ctor | MD 106. County Anne An | | | polis | | | | | 1 | 10d. Inside City Limits 1 □MYes 2 □ No | |
| | 23a or 28 | Funeral Director | 10e. Street and Number 969 Lanna Way | | | 10f. Zij | Code | 21401 | | USA | √het Cour | ntry? | |
| 21215-0020 | 72 hours after death with the Maryland naturel', or items 23a or 28s-f ehow first Examiner must be neutred at | þ | 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 ¼ Yes 2 ☐ No If Yes, Give Yeer or Detes: WW | | 13. Was Dece If Yes, spe 1 \(\superscript{\text{Yes}}\) | | Hispanic Origin? (Spen, Mexican, Puerto Specify: | pecify Yes or No- Rican, etc.) | 14. Reca Blac Specify | k, White, | can Indien, etc. hite | |
| 5 | 72 h natu | etec | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16e. | Decedent's Usu | al Occup | pation during most of work | kina | 16b. Kind of Bu | siness/In | dustry | |
| 21 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel, or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examerer must be notified and once. | D S | Elementary/Secondary (0-12) | College (1-4or 5+) | | life. DO NOT u | ise retire | d) | · · · · · · · | | | | |
| 21 | | Be Completed | 12 | 4 | Con | nmunicat | ions | Supervis | | NASA | | | |
| nd | | | 17. Fether's Name (First, Middle, Last) | | | | | 18. Mother's Nem | | Maiden Sumem | Θ) | | |
| a | Vent Vent rked rtic e | 10 | Merton A. Ross | | | | | Merta | Davis | | | | |
| , Maryland | 19a. Informant's Name/Reletionship (Type, Print) Patricia Constantini PATRICIA COSIANIINI | | | | | | s (Stree rin | tand Number or Ru g Pines | dRive, | r, City or Town, Ithaca | State, Zip | 14850 | |
| Baltimore, | Pages 1 a ent of He nt: If Item ry or othe | | 20a. Method of Disposition 1 □ Burlal 2 ☑ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify | Removal from State | Ob. Place of cemete Metr | f Disposition (Na ry, cremetory or o O Crema | me of other place at 0.2 | ry 2 | Date 2/10/96 | 20c. Location - Balt | | | |
| Balti | permit. Departminiontal | | 21. Signature of Fugeral/Service Licen | 100/// | | Harde | sty | ess of Facility Funeral | | | | | |
| | | - | 23a Part 1 Enter the disease or com- | plications that caused the | doath Do | 12 R | idge | ely Ave. | Annap | olis, | MD | 21401 Approximete | |
| L . | | | 23a. Part1. Enter the disease, or companion shock, or heert failure. List only | one ceuse on each line. | death. Do | not enter the mod | de or dy | ing, such es cardiac | or respiretory en | rest, | 1 | Interval Between Onset and Death | |
| į. | Physician /Medical Examiner | | Immediate Cause (Final disease or condition | · Multi | 04 | Friur | ies | | | | 1 | Onoot and Double | |
| 10 | L V | | resulting in deeth) | | | consequence of) | : | | | | 1 | | |
| | | ne l | | h | | | | | | | 1 | | |
| | icate be executed physician and s the burial-transit | Examiner | Sequentially list conditions, | Due | to (or as a | consequence of) | 4 | | | | | | |
| 68760, | tificate be execut og physician and as the burial-tran | | | | | | | | | | | | |
| 87 | sate t | Medical | that initiated events resulting in death) Lest | Due | to (or as a | consequence of): | | | | | | | |
| | 5 0 6 | N N | | d | | | | | | | | | |
| Вох | death ce e attendir ed for use | an | _ | d | | | | | | | 1 | | |
| | he at | SC | Part II. Other significant conditions or | ontributing to death but no | t resulting i | n the underlying | cause gi | ven in Part I. | 23b. Did t | obacco use co | ntributa to | o the causs of death? | |
| s, P.O | uires that the death cer signed by the attendin Id be detached for use | by Physician/ | va | | | | | | 101 | res 2 No | 3 ☐ Proi | bably 4 Unknown | |
| Records, | aw requisite been 2 should | | | | | | | | | an autopsy med? | av | fere autopsy findings vallable prior to empletion of cause deeth? | |
| | The law ete has b page 2 si | 5 | | | | | | | 1 🗆 Y | es 2 No | 1[| ☐Yes 2☐No | |
| | | Be (| 25. Was case referred to medical examiner? | | | | | 26. Place of Dea | th (Check only o | ne) | | | |
| > | 5 00 | 20 | 1 XYes 2 No | Hospitel: 1 ☐ Inpatient | 2/ENER/O | utpatient 3 D | OA Ot | her: 4 Nursing H | ome 5 Resid | lence 6 DOth | er (Specil | fy) | |
| 0 | g Ph er th | | 27. Manner of Death | 28a. Date of Injury (Month, Day Yea | 28b. | Time of | 28c. Inju | iry at | 28d. Describe h | ow injury occur | red | | |
| O | 28c. Date of Injury. 28d. Date of Injury. | | | | | | | Yes 2 No | Oriver | -auto | aut | to collision | |
| Division | 3 Sulcide 4 Homlcide 3 Sulcide 4 Homlcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | 28f. Location (S | Street and Numb | | al Route Number, | | |
| ā | din din | er | 4 LI Homicide | building, etc. (Specify) Roadway R+ 198 | | | | | | | -och | oridge RA. | |
| (| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely lilled in by the funeral | edical C | | ysician: To the best of my hiner: On the basis of exa and manner stated. | knowledge | death occurred | | | | ause(s) and ma | nner as s | steted. | |
| | within To the comple | M M | 29b. Signeture end title of cortifier | MI | | 29 | c. Licen | se number | | 29d. Date signe | d (Month, | Day, Year) | |
| | 5 7 % S | | | 161 | | | | | | | | | |
| | 2- | O.C.M.E. FEB. 0 | | | | | | / , | 1770 | | | | |
| | 10 | | 30. Nome and address of person who a | completed cause of death | | | Str | eet, Ba | ltimore | , Mary | lan | d 21201 | |
| | Sta Registr | | 31. Date filed (Month, Dey, Year) FFR 1 9 1006 | 32 Registrar's S | Signature | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 96 03592

| | | | | | Cei | rtificate of | Death | | Reg. No. | 03 | 392 | | | |
|-------------------|---|---------------------|---|--|--|--|---|---------------------------------------|------------------------------------|--|--------------------------------|--|--|--|
| | Physic | ian | 1. Decedent's Name (First, Middle, Last, |) | | | | 2. Date of De Month | | | | | | |
| | /Medi | cal | | and Ross | | | 41. 015 | Feb.8, | 1996 | | Z. I Valli | | | |
| 4 | Examir | ner | 4a. Facility Nama (If not institution, give Annapolis Conv | | Center | | 4b. City, Town, or Annapo | | | | del | | | |
| - | Funeral | | 5. Social Security Number 6. Sec | x 7. Age (In | vrs. last birthday) | 1 1 | r If Undar 24 Hrs | 8. Data of Birl | | | | | | |
| | Director | | 214-05-0547 Usual Rasidence of Decedent | M 2□xF 84 | Yrs. | WOILING Days | S HOUIS WIII | Nov.6, | 1911 | Maryl | and | | | |
| | ahow show | 5 | 10a. Stete 10b. County MD Anne Aru | | City, Town or Lo | | | | | | | | | |
| | the N 28a-f | rect | 10e. Street and Number | | - | 10f. Zip Coda | | | 10g. Citizen of 1 | | 4.6 | | | |
| | 23a o | ral Di | 815 Chesapeake | Avenue | | 21403 | | | USA | | | | | |
| 21215-0020 | 72 hours after deeth with the Maryland natural', or items 23a or 28a-f show dical Examiner must be notified at | by Funeral Director | 11. Merital Status 1 ☐ Never Merriad 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedant Evar i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Detes: | | Was Decedent of If Yas, specify Cul 1☐ Yes 2☑ No | Hispanic Origin? (S ban, Mexican, Pual Specify: | Specify Yes or No to Ricen, atc.) | | ck, White, etc. | | | | |
| 15-(| n 72 h | ietec | 15. Decedent's Edu (Specify only highast gred | cation e <i>completed)</i> | 16a. Dece (Give | dent's Usuel Occu | upation a during most of wo ed) | orking | 16b. Kind of B | Pounty of Death The Arundel 9. Birthpieca (Stata or Foreign Country) Maryland 10d. Inside City Limits 10d. Inside Ci | | | | |
| 212 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show mithoritant: if item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | Be Completed | Elementery/Secondery (0-12) | College (1-4or 5+) | Sale | | | | Pot | ail | | | | |
| | | | 17. Fether's Neme (First, Middla, Last) | - | | FEI, | 18. Mother's Ne | ma (First, Middle, | Meiden Suman | | | | | |
| Maryland | | To | Harry F. Morela | | | | Ida | Faus | | | | | | |
| | | | 19a. informent's Neme/Reletionship (Ty William H. Sorr | Filliam H. Sorrell Jr. 1141 Bay Ridge Road, Annapolis, MD 214 | | | | | | | | | | |
| Baltimore, | | | 20a. Method of Disposition 1 □ Burlai 2 □ Cremetion 3 □ R | 20 | b. Piece of Dispo cemetery, crer | sition (Neme of matory or other pl | ece) | Dete | 20c. Location - | City or Town, | Stete | | | |
| ţ | | | 4 ☐ Donation 5 ☐ Other (Specify) | // Ce | | uff Ce | | 2/10/96 | Anna | polis | , MD | | | |
| Bal | permit. Departr Importa | | 21. Signature of Funeral Service Liceries | 1 | H | | ress of Facility Y Funera ely Ave | | | MD 2 | 1401 | | | |
| | | | 23a. Pert1. Enter the disease, or compli- shock, or heart tallure. List only or | | Ap | proximate erval Between | | | | | | | | |
| | Physician / Medical | | immediete Ceuse (Finei | Roel | ur (| ANCER | | | | On | | | | |
| | Examiner | | diseasa or condition resulting in death) | I | o (or es e consec | | - | | | 6 | Months | | | |
| - | D # | Iner | | | 0 (01 43 4 001340 | dence or). | | | | 1 | | | | |
| oʻ | law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury | Due t | o (or es e conseq | juence ot): | | | | | Deel | | | |
| 68760, | ate be hysicia the bu | Medical | Ceuse (Diseese or injury that initiated events resulting in death) Last | Due to | o (or as a conseq | uence of): | | | | 1 | | | | |
| Box 6 | certific iding p | √Me | | | <u> </u> | | | | | | | | | |
| | death cer e attendir d for use | iciar | Pert ii. Other significant conditions con | tributing to death but not | resulting in the u | ndarhilna causa a | iven in Pert i | 23h Did i | lohacco uae co | ntribute to the | a cause of death? | | | |
| P.0 | es that the digned by the be detached | Physician/ | | 1entia | resouring in the di | nderlying cease g | IVOIT III POIL I. | 1 🗆 1 | 1.2 | | | | | |
| of Vital Records, | uires tha | d by | | | | | | 24e. Was | an eutopsy | 24b. Were a | autopsy findings | | | |
| 900 | aw requints been si | Completed | | | | | | | rmad? | comple | ble prior to etion of cause | | | |
| E B | The ate h | Com | | | | | | 101 | as 2 No | 1 □ Ye | es 2 No | | | |
| Vita | Physician: The | Be | 25. Wes case refarred to medicel examiner? | ospital: | | | | eth (Check only o | ne) | | | | | |
| | Physical direction | - To | 1 ☐ Yes 2 No ☐ | 1 □ inpatient 2 | 28b. Time of | R 3LI DOA | | Homa 5 ☐ Resid | tence 6 Oth | | | | | |
| lon | S TAN | ation | 1 Neturai 5 Pending 2 Accident investigation | 28a. Dete of Injury (Month, Dey Year |) Injury | Wo | ork? ☐Yes 2☐No | 200. 200.001 | iow injury occur | 160 | | | | |
| Divisi | al or the s afterde il Dieso d in by th | Certification | 3 Suicide 6 Could not be datermined | 28a. Place of Injury - A building, etc. (Sp. | t home, ferm, str | aat, factory, office | | 28f. Location (S City or Tox | Street and Numb vn, Stete) | er or Rural Ro | oute Number, | | | |
| | To the Hospital of within 24 hours at To the Funeral D completely filled in | edical (| 29a. Certifier Check only one) Certifying Phys | ician: To the best of my ler: On the basis of exam and menner stated. | knowledge, deeth inetion end/or inv | occurred et the trestigetion, in my | ime, dete end plec opinion, deeth occ | e, and due to the curred at the time, | ceuse(s) and ma dete and piece, | nner as stated and due to tha | d. cause(s) | | | |
| | Nithin Fo the Somple | Me M | 29b. Signatura and titia of certifiar | and mornior stated. | | 29c. Licen | sa number | | 29d. Data signe | (Month, Day | , Year) | | | |
| | . , | | 1 Kall m 1 138168 | | | | | | 2/8 | 96 | | | | |
| | 10 | | 30. Name and address of person who co | mpleted cause of deeth (i | item 23e) (Type, | Print) Medica | e Park | very A | NASPUL | 18 21 | 101 | | | |
| | Sta Registr | | 31. Dete tiled (Month, Dey, Year) | in Davidsen Man | AUL | | | | | | | | | |

DIVISION OF VITAL RECORDS. P.O. BOX 68760

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| | death. |
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DIVISION OF VITAL RECORDS, P.O. BOX 6876(
DIVISION OF VITAL RECORDS, P.O. BOX 6876(
DIVISION OF VITAL RECORDS, P.O. BOX 6876(
DIVISION OF VITAL PROPERTIONS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

SALVE FINERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | | | | | |
|--------------------------------|--|---|---|---------------------|---|--|--------------------------|--|--|--|--|
| | DECEDENT'S NAME (First, Middle, Last) HOWARD | MELVIN | BAY | | | 2. DATE OF DEATH MONTH D | 0 1996 YEA | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER | | In yrs. last birthday) F | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 0. B | IRTHPLACE (State or Foreign | | | |
| | 717-07-8693 9s. FACILITY NAME (If not institution, give str | 1 M 2 F | 92 YAS. | CITY, TOWN O | R LOCATION OF DE | MAY 26, | the second second second | MARYLAND OF DEATH | | | |
| TOR | Saint Joseph Med | dical Center | | To | wson, Mai | ryland | | altimore | | | |
| DIRECTOR | MD a 10b. COUNTY | N/A | 10c. CITY, TO | OWN OR LOCAT | ON ALTIMORE | MD. | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| FUNERAL | 100. STREET AND NUMBER 2731 CHESLEY AVE | | | 101. | ZIP CODE 2123 | 10g. CITIZEN OF WNAT COUNTRY? | | | | | |
| BY FUNE | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, spe | ENDENT OF NISPAN pelfy Cuban, Maxica 2 NO Specify | RACE — American Indian, Black, Whita, etc. Specify: WHITE | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 +) N/A | 18a. DECEDENT'S USL (Give kind of work life. Do NOT use re ENG INEER | done during mos | RAIL ROAD | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) THOMAS RA | AY | | | 18. MOTNER'S NA LOUISE | ME (First, Middle, Maiden MUNICH | Sumame) | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) M ARGARET C. RAY | | 0) | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 1 Surfal 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of careful and control of the c | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD BALTIMORE MD. 21234 | | | | | | | | | | |
| | 23. PART / Enter the diseases, or complications their caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other eignificent conditions DID TOBACCO USE CONTR | | | | uncertail | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY | | | |
| M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE DF DEATH (| Check only one) | | | | | | | |
| SIC | 1 YES 2 NO | HOSPITAL: 1 Intellent 2 ER/Outp | etlant 3 DOA 4 | THER: Nursing Nome | e 5 🗆 Residence | 6 Other (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Neutral 5 Pending 2 Nectdent Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | r wo | URY AT RK? 'ES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURE | D | | | |
| 0 | 3 Suicide 6 Could not be datarmined | 28s. PLACE OF INJURY building, etc. (Speci | — At home, larm, stree | et, lactory, office | | 28f. LOCATION (Street City or Town, State | | ural Route Number, | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CHITIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as steted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and the cause(b) and the cause(b) and the cause(b) and the cause(c) | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE DF CERTIFIER | | | | 29c. LICENSE NUI | MBER | 29d. DATE SIG | BNED (Month, Day, Year) | | | |
| TO BE | Alicat | 15/ | | | H43974 > Fub /0, 9 | | | | | | |
| | 30. NAME AND/ADDRESS OF PERSON WHO | ST. JOSEPH ME | EDICAL CEN | | | | | | | | |
| FFB 1 3 1996 Jaw Druger Rend H | | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygieni

| | | | | | viai yiai | | | | Death | mornar 11 | Reg. Nc " |)6 C | 13594 | |
|-----------|---|------------------|--|---|----------------|---|-------------|-----------------|--------------------|--------------------|------------------------|------------------|--|--|
| | Dhuala | | 1. Decedent's Name (First, Middl | e, Last) | 70.00 | | | | | 2. Date of Do | eath Day | Yaar | 3. Time = U+-th | |
| J | Physic /Medi | | GERTRUDE | ANN | | | | RUSS | 30 | FEBRUA | | | 11:15 | |
| | Exami | | 4a. Facility Nama (If not institution | n, give street and numbe | er) | | | 1 | 4b. City, Town, or | Location of Deal | | ty of Death | | |
| | | | 1000 DUMBARTON | ROAD | | | | | GLEN | BURNIE | ANNE | ARUND | FI. | |
| т | Funeral | Г | 5. Social Security Number | 6. Sax 7. | Aga (In yrs. | last birthday) | | er 1 Yaar | If Under 24 Hrs | 8. Date of Bi | | - | aca (Stata or Foraign | |
| | Director | | 214-12-2905 | 1□M 20 F | 77 | Yrs. | Months | Days | Hours Min | 01-19- | | MARYL | | |
| | D | | Usual Residence of Decedent | | | | | | | | | | THILD | |
| | arylan show | | 10a. State 10b. County | | 10c. Cit | ty, Town or Lo | ocation | | | | | 100 | d. Insida City Limits | |
| | tha Mar 28a-f si notified | Ş | MARYLAND AND | NE ARUNDEL | | GLEN : | BURN: | ΙE | | | | | 1 ☐ Yes 2 No | |
| | or 28 | Te. | 10e. Street and Number | *************************************** | | | | ip Coda | | | 10g. Citizen of | What Countr | y? | |
| | th wit | 0 | 1000 DUMBARTON | ROAD | | | | 21060 | | | | | | |
| | hours after death with the Meryland turet; or items 23s or 28s-f show all Examinet must be notified at | Funeral Director | 11. Marital Status | 12. Was Deceda | nt Ever in U | In U,S. 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarica Black, Whita, a | | | | | n Indian, | | | |
| 0 | or its | E. | 1 Never Married 2 Marr | Armed Force | | If Yes, specify Cuban, Mexican, Pua | | to Rican, etc.) | BI | ack, Whita, at | tc. | | | |
| 020 | L's | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Yaar or Date: | s: | | 1 🗆 Yas | XXNo | Specify: | | Speci | ty: W | HITE | |
| 215-0020 | 72 hours natural', Jical Ex | P | 15. Decedan | it's Educetion | | 16a. Dece | dent's Usi | ual Occup | pation | | 18b. Kind of I | Business/Indu | ıstry | |
| 715 | ole 7 | pie | | st grada completed) | | (Give | kind of w | ork done | during most of wo | rking | | | | |
| 212 | d 2 should be filed within th and Mental Hygiena. 7 is marked other than "treumatic event, tre Me. | E | Elementary/Secondary (0-12) 12 | College (1-4d | or 5+) | HOMEMA | AKER | | | | OWN H | OME | | |
| | | 0 | 17. Father's Nama (First, Middle, | Last) | | | | | 18. Mother's Na | me (First, Middle | | | | |
| Maryland | | To Be Completed | EDWARD | NOONAN | | | | | JULIA | | | WOOD | TE | |
| 2 | should b nd Ments marked marked | Ĕ | 19a. Informant's Name/Relations | | | 10b Mailie | na Addres | e (Street | and Number or R | | nor Cibros Tour | | | |
| Ma | | | | | | | | | | | | | | |
| o, | i Haai I Haai Item 2 other | | JOHN F. RUSSO 1000 DUMBARTON ROAD, GLEN BURNIE, MD. 2106 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, cemetery, cramatory or other place) | | | | | | | | | | | |
| Baltimore | Sept 10 | | 1 Buriai 2 □ Cremation | 3 □Removal from Sta | 148 | | | | | 2/12/96 | | | | |
| Ħ | srtmo artant ortant injury | | GLEN BURNIE, MD. | | | | | | | | | | | |
| 3al | appar mpor ny le | | 21. Signature of Futeral Service | Liosinsee | 2 / | - | Name a | nd Addra | ss of Facility S] | NGLETON | FUNERA | L HOME | | |
| - | 00240 | | | 1 Det | =/ | 1 | SECO | OND A | VENUE S. | W., GLE | N BURNI | E, MD | 21061 | |
| | 4.8 | | 23a. Party. Enter the disease or shopk, or heart failure. List | complications that caus | sed the daat | h. Do not ant | er tha mo | da of dyin | ng, such as cerdia | c or raspiratory a | arrest, | 1-1 | Approximata Interval Between | |
| N | Physician | | | any and couse on each | T III TO. | | | | | | | 6 | Onset and Death | |
| 4 | /Medical | | Immediate Cause (Final disaasa or condition | (01. | 10 | 0. | | | | | | 1 | 10101 | |
| - | Examiner | | resulting in death) | a. Cooq | Due to /c | or as a consec | wance of | 1. | | | | | (0/)0 | |
| | | Je | | 110 | 4 | / | 1001100 01 | | 1.10 | | | 1 | 7 4- | |
| | outed | Examiner | Sequentially list conditions | Due to (or as a consequence of): | | | | | | | | I THE OW. | | |
| oʻ. | exec tal-tr | EX | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): | | | | | | | | | 1 | n 100 | |
| 68760, | icate be executed physician and s the burial-transit | edical | Cause (Disease or Injury that initiated events | С. | Digo | r as a conseq | 0 | | an f | Qi hu | Mune | | | |
| 68 | tificate g phys | edi | resulting in death) Last | | Брело (о | i as a conseq | uerice or) | | 1 | | | | 7 10. | |
| Box | ndin | 2 | ' | d. h | 300 | ende | al | 6 | ujant | 76- | | | (March | |
| m | death cer a attendin ed for usa | Physician/N | Don't Other dealflood | | 0 | | Sanuara | Cestillic e | () | l and min | | | | |
| Ö | tha o | 1ys | Part II. Other significant conditio | ins contributing to death | Dut not res | ulting in the u | nderlying | ceuse giv | en in Part I. | | S / | / | the cause of death? | |
| <u>α</u> | that ed b deta | | | | | | | | | 10 | Yes 20 N6 | 3 Probe | ably 4 Unknown | |
| ds, | requires that tha death cer een signed by tha attandin hould be detached for usa | d by | | | | | | | | 04: 144 | | Odb Was | a autonou din din a | |
| Record | redu | Completed | | | | | | | | | s an autopsy ormad? | avail | a autopsy findings lable prior to pletion of ceuse | |
| ec | 8 8 8 | 현 | | | | | | | | | | of de | eath? | |
| Ш | The in | Ö | | | | | | | | 1 🗆 | Yas 2000 | 10 | Yes 20 No | |
| Vital | iclan: The certificate rector, pag | Be | 25. Was cese referred to medical | | | | | | 26. Place of De | ath (Check only | one) | | | |
| > | Physician: this certific rai director, | 10 | examinar? | Hospitai: 1 ☐ Inpa | itlent 2 | ER/Outpatien | it 3□ D | OA Oth | or: | lome 5 Res | | her (Specify) | | |
| Jo (| ar this | | 27. Manner of Death | 28a. Date of In | | 28b. Time of | | 28c. Injur | | 1 | how injury occu | | | |
| io | o fur | 읊 | 1 Natural 5 ☐ Pending 2 ☐ Accident investig | | Jay 1 Gar) | Injury | М | | Yes 2 □ No | | | | | |
| Division | or Attending I after death. Director: After I in by the funer | Certification: | 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi | ined 288. Place of I | Injury - At ho | ome, farm, str | eet, factor | ry, office | | 28f. Location | Street and Num | ber or Rural I | Route Number, | |
| Ö | d in din | ert | building, etc. (Specify) City or Town, State) | | | | | | | | | | | |
| | Hospital 24 hours a Funeral C | | 29a. Certifier 1 Certifying | g Physician: To the bes | st of my kno | wiedge, death | occurred | at the tin | ne, date and place | and due to the | cause(s) and m | anner as stat | ted. | |
| | to the Hospital or Attending Physician: The Manus after death. To be Funeral Director: After this certific completaly filled in by the funeral director. | edicai | (Check only 2 Medicat E | Examiner: On the basis and manner: | of examinal | tion and/or inv | astigation | n, in my o | pinlon, death occu | irred at the time, | date and place | , and dua to the | he cause(s) | |
| | d du | Me | 29b. Signature and title of eachitier | | | | 29 | c. Licens | a number | | 29d. Data sign | ed (Month, Dr | ay, Year) | |
| 1 | 270 | | 1 | 1 | (|) | 6 | (0 / | DE | 8 | 01- 1 | 101 | , | |
| | 1 | + | | | _ | | | 7 (| 53 00 | / | 02/1 | 111 | | |
| | 6 | | 30. Name and address of person | 9 | | | | | | | (| 1 | | |
| | | | Charles J. Wi 31. Date filed (Month, Day, Year) | u. M.D. 1 | 600 5 | G. Cra | in | hwy, | #306, | Glen Bu | ırnie, | MD. | 21061 | |
| | Sta Registr | | FFR 1 3 1996 | John alle | NALCO AND | 26. | | | | | | | | |

Frank South Section 1886

State of Maryland / Department of Health and Mental Hygiene 96 03595

| | | | | | | Certifica | ate of | Death | | Reg. No. | | | | |
|------------|--|------------------|---|--|--|-----------------|--------------------|---|-------------------|------------------|---|-----------------|------------|--|
| | 11 19 19 | | 1. Decedant's Nama (First, Middla, Li | ast) | | | | | 2. Data of D | eath | | 3. Tima o | f Death | |
| | Physic | | DEBORAH | М. | SH | EUBRO | OK | | Month FEB. | | | 6.35 | PM | |
| | /Medi Exami | | 4a. Facility Nama (If not institution, gir | | | HODRO | | 4b. City, Town, or | | | | 0.55 | LIT | |
| 1 | - Admin | | 1030 IRIS AVE. | | | | | BALTIM | ORE | | | | | |
| т | Funeral | Г | | | ga (İn yrs. last birt | | dar 1 Yaar | If Undar 24 Hrs | 8. Data of B | | | olaca (Stata | or Foreign | |
| | Director | | 219-78-8869 Usuai Rasidance of Decedant | 1□M 2Å F | 33 | Yrs. Month | ns Days | Hours Min | Oct. 4 | 1962 | Mary | land | | |
| | P Ma | | 10a. Stata 10b. County | | 10c. City, Town or Location | | | | | | | 0d. Insida Ci | ity Limits | |
| | dary dary | ō | Manual and N | /A | D - 1 + 4 - | | | | | | | | | |
| | r 28a-f show | 2 | Maryland N 10e. Street and Number | / A | Baltin | | Zip Code | | | 10a Citizan a | Λ | | | |
| | 23a or | Funeral Director | 1030 Iris Avenue | | | | 1205 | | | | | itry r | | |
| | Jeath The 2 | Jera | 11. Maritai Status | 12. Was Dacadan | t Evar In U.S. | | | Hispanic Origin? (| Specify Yas or N | | | an Indian. | | |
| 020 | 72 hours efter death with the Maryland natural', or itema 23a or 28a-f show dical Examiner must be northed at | by Fur | 1 Nevar Married 2 Married 3 □ Widowed 4 □ Divorced | Armed Forcas 1 Yas 2 If Yas, Giva Yaar or Datas | Z No | 1 | pecify Cut 2 No | Hispanic Origin? (ban, Maxican, Pua Specify: | to Rican, atc.) | | ack, Whita, | atc. | | |
| 21215-0020 | 72 hours "natural", | Completed | 15. Decedent's E (Specify only highast gr | ducation | | Decedent's U | sual Occu | pation during most of we | dina | 16b. Kind of | Business/In | dustry | | |
| 21 | within on the series. | ple | Elamantary/Secondary (0-12) | Collega (1-4or | 5+) | lifa. DO NOT | usa ratin | i <i>during</i> most or wo | onking | | | | | |
| | d wild | NO. | 10th grade | | | lair St | ylis | t | | Self-E | mploy | ed | | |
| Maryland | permit. Peges 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any injury or other traumatic event, the Medical anges. | Be | 17. Fathar's Nama (First, Middla, Las |) | | | | 18. Mothar's Na | ma (First, Middle | a, Maiden Suma | ma) | | | |
| <u> a</u> | | To | Stanley Gerard I | szkiewicz | | | | Frances | s Marie | Novotny | | | | |
| an | sho and A | - | 19a. Informant's Name/Raletionship | | 19b. | Meiling Addra | ass (Stree | t and Number or R | lural Routa Numi | ber, City or Tow | n, Stata, Zip | Code) | | |
| | and 2 paith of 127 is | | Richard J. Sheub | rook (Hush | pand) 103 | 0 Iris | Ave | nue. Bali | timore. | Marylan | d 212 | 0.5 | | |
| ē, | Herm offine | | 20a. Mathod of Disposition | | 20b. Place of | Disposition (# | Vema of | | Data | | | | | |
| altimore, | Peges nent of i int: if ite iry or o | | 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) st. Stanislaus Cem. 2/13/96 Baltimore | | | | | | | | | 10 222 1 0 | nd | |
| | orter Injur | | 21. Signatura of Funaral Service Lica | | 51. 51 | 1 | | ass of Facility | 90 | Daitim | ore, i | laryla | IId | |
| Ba | permit. Departr Importu any inji | | Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Marylane 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock heart failure. List only one cause on each line. | | | | | | | | | | | |
| | - | | 23a. Part1. Enter the disaase, or com | pplications that cause | d tha daath. Do n | ot antar tha m | oda of dy | ing, such as cardia | c or raspiratory | arrast, | Jana | Approximat | a | |
| Я | Physician | | Shoot a haar landa. List offly | Ona Causa On aacin | int let. | | | | | | | | | |
| J. | /Medical | | Immediete Causa (Final | iLna | 10 2410 | | | | | | 1 | | | |
| | Examiner | | disaasa or condition rasulting in death) | a. HAI | 34104 | | 0 | _ | | | 1 | | | |
| | | ē | | | Dua to (or as a c | onsequence o | or): | | | | į | | | |
| | uted | Examiner | | b. ——— | | | | | | | | | | |
| - | ertificate be executed ling physician and e as the buriel-trensit | Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or Injury | | | | | | | | 1 | | | |
| 68760, | Sicial buri | | Cause (Disease or Injury that initiated evants | C | | | | | | | | | | |
| 289 | phy: | Medical | rasulting in death) Last | | Dua to (or as a c | onsequanca o | 1): | | | | 4c. County of Death N/A 9. Birthplaca (Stata or Foreign Country) 1962 Maryland 10d. Insida City Limits 1 | | | |
| × | requires that the death certificete be executed some signed by the attending physician and hould be deteched for use as the buriel-trensit | ZW. | L | d | | | | | | | | | | |
| Bo | that the death cer ed by the attendin deteched for use | Physician/ | Part II. Other classificant conditions | | 12 - 2 20 20 40 - 7 | acid tell a se | | Contraction | 001 01 | | | | | |
| P.O. | t the d by the teched | ys | Part II. Other significant conditions of | contributing to death t | out not rasulting in | tne undanyin | g causa g | ven in Part I. | | | | | | |
| | that ned b | | | | | | | | 1 | Yee 2 № No | 3 □ Pro | bably 4 | Unknown | |
| Records, | w requires that been signed to should be det | d by | | | | | | | 24a Wa | s an autopsy | 24b. W | ara autopsy f | indinas | |
| Ö | | Completed | | | | | | | perf | formed? | av | allable prior t | 0 | |
| 360 | 8 50 | d L | | | | | | | THA | petria | of | death? | | |
| 100 | E ag | ပိ | | | | | | | 1 🗆 | Yas 20 No | 1[| Yas 2 | No | |
| Vital | Physician: The cartificate ral director, pag | Be | 25. Was casa raferrad to medical exeminar? | | | | | | eth (Check only | ona) | | | | |
| of | physic this c al dire | 10 | XX Yas 2□ No | Hospital: 1 Inpati | ent 2 ER/Out | patient 3 | DOA O | har: 4 Nursing I | Homa 5 Ras | ildanca 6 🗆 O | thar (Specil | y) | | |
| ono | | :uo | 27. Mannar of Death 1 □ Natural 5 □ Panding | 28a. Data of Inju | ay Year) In | jury | 28c. Inju | iry at ork? | | how Injury occi | | - | | |
| 9 | Attending r death. ector: After by the fune | at | 2 Accident Invastigetio | | 96 FOUL | 1854 W | 10 | Yas 2 No | SWSIE | GT HAL | heo - | 000 | | |
| Divis | or Affendation death | Certification: | 3 Sulcida 6 Could not b 4 Homicide datermined | 28a. Placa of in | jury - At homa, far | m, straat, fact | ory, office | | 28f. Location | (Straat and Nun | ber or Ruri | / Routa Num | ber, | |
| Ø | | Ce | | bonding, a | | ente | | | | | SAUDI | WRJ | wh | |
| -2- | Hosp 4 hox Fune lety fi | edical | | niner: On the basis of | of my knowledge, of axamination and | deeth occurre | | | | | | | .) | |
| | To the He within 24 To the Fu | Med | 29b. Signatura and titla of cartifiar | and mannar st | ateg. | | On Lines | sa number | | 20d Data at- | ad /Ada-st- | Day Vassi | | |
| | 5 ¥ ₹ 8 | _ | 255. Signatura and titla of cartiflat | 11 . | | 1 | | C.M.E. | | _ | | | | |
| | 2 | | munione Who | Youll | | | | | | | | | | |
| | ツ | | | completed causa of | | | | | | | | 0100 | | |
| | | | | KOREU | | | stre | et, Bal | timore | , Mary | Tand | 2120 | 1 | |
| | Sta | - 1 | 31. Data filed (Month, Par Hear) | 1996 32. 7.9 | ar's Signature | Carlett | | | | | | | | |
| | Registr | ar | . 2010 | | | | | | | | | | | |

OR ATTENDIGENEE. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPIN. OF ALTEATING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

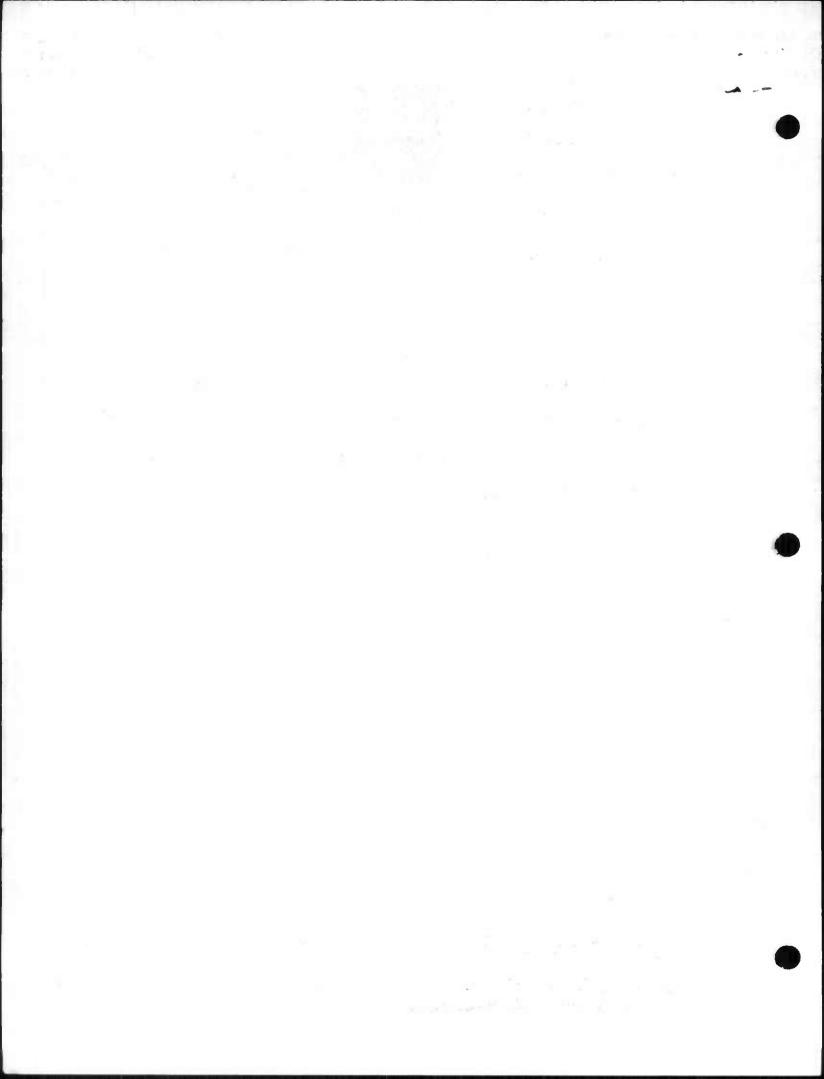
TO THE FUNERAL INTERIAL After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| E | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|-------|---|---------|
| STRAR | CERTIFICATE OF DEATH | DEG NO |

| - 0 | REGISTRAR | | CERTIF | ICATE O | F DEATH | REG. N | Ю. | | | | | |
|--------------------|--|---|----------------------------|--|---|---|---------------------|---------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | | |
| | Frank Paul Sall | ONO | | | | Feb. | ONTH BAY 1996 18:34 | | | | | |
| - 1 | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | J // | | IPLACE (State or Foreign | | | |
| | 220-20-8879 | 1 X M 2 - F | 69 YRS. | MONTHS DAYS | HOURS MIN. | Jan. 21, 1927 Maryland | | | | | | |
| DIRECTOR | 90. FACILITY NAME (If not institution, give : Church Hospital | street and number) | | Baltin | OT LOCATION OF D | EATN | 9c. COU | NTY OF D | EATN | | | |
| 5 F | RESIDENCE OF DECEDENT | | 1 | | | | | | | | | |
| 2 | | | | Y, TOWN DR LO | | | | | 10d. INSIDE CITY LIMITS? | | | |
| | | N/A | B | altimor | .e | | | 1 XYES 2 NO | | | | |
| Z I | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | | 10g. CITI | VHAT COUNTRY? | | | | |
| E | 20 S. Washington | St. | | 21231 | | | | United St | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVI | | | | NIC DRIGIN? (Specify | Yee or No- | 14. RACI | E — American Indian, k, White, etc. | | | |
| BY F | 1 Never Merried 2 N Merried 3 Widowed 4 Divorced | FORCES? 1 Y | | If yes, | epecify Cuben, Mexic ES 2 X NO Speci | an, Puerto Rican, etc.) /y: | | Spec | | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16e. DECEDENT'S | USUAL OCCUPA work done during se retired.) | TIDN most of working | BUSINESS/INC | DUSTRY | | | | | |
| iii lii | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | | | | | |
| d L | | 2 years | ical | Truck | na | | | | | | | |
| ō I | 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Sumeme) | | | | | | | | | | | |
| BE | Carl Antonio Sal | Lese. | | | Angelis | re Pallad | ino | | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | Route Number, City or | | Code) | | | | | | | | |
| 2 | | | | | | | | | | | | |
| ı | 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE DISPOSITION //Name of DATE 20c. LOCATION — City or Town, Stetle | | | | | | | | | | | |
| - 1 | Viveuries 2 Cremetton 3 Removal from State State Commetter | | | | | | | | | | | |
| ŀ | 21. SIGNATURE OF FUNERAL SERVICE LI | | jardens of | Faith | COMOTOTU | 7/1/96 | saltim | ore, | Marykand | | | |
| | The state of the s | DENSEL | | Viida- | Ruck Fund | otal Home | of Du | ndal | k, Inc. land 21222 | | | |
| | T Kent | Cone | · mak | 7922 | Wise Aver | rue Dunc | talk, | Mary | land 21222 | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| ERT | that Initiated events resulting in death) LAST | | | | | | | | | | | |
| - 11 | PART II. Other algnificent condition | na contributing to dea | th but not resulting | In the underly | ing cause given in | Part I 24a WAS | AN AUTOPSY | 241 | . WERE AUTOPSY FINDINGS | | | |
| ₹ | The state against sometime | | in out not readining | m (no ongon) | my cause given in | PER | FORMED? | 1 | AMILABLE PRIOR TO | | | |
| ă | | | | | | 1 _ YES | 2 X NO | | COMPLETION OF CAUSE OF DEATH? | | | |
| ¥ | | | | | | | | | 1 YES 2 ND | | | |
| ÷ l | DID TOBACCO USE CONT | RIBUTE TO CAUSI | OF DEATH Y | ES NO | UNCERTA | N 🗆 | | | | | | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEA | TH (Check only o | 70) | | | | | | | |
| S | EXAMINER? | HOSPITAL: | Outpetient 3 DOA | OTHER: | ome 5 Residence | 6 ☐ Other (Specify) | | | | | | |
| PHYSICIAN: MEDICAL | 27. MANNER OF DEATH | 28s. DATE OF INJU (Month, Day, Ye | IRY 25b. TII | AE OF 28c. | INJURY AT WORK? | 28d. DESCRIBE HO | W INJURY OC | CURED | | | | |
| BY C | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF IN. building, etc. | JURY — At home, farm, | | YES 2 NO | 281. LOCATION (Str. City or Town, St | | r or Rural | Route Number, | | | |
| ETEO | 4 Homicide determined | Donolling, etc. | ориску) | | | CRY OF TOWN, SI | are) | | | | | |
| COMPLET | (Orlock Strif) | SICIAN: To the best of my I IER: On the beels of apartic | | | | | | | e) end menner es stated. | | | |
| BE | 29c. LICENSE NUMBER 29d. DATE, SIGNED (Month, Day, Year) 29c. LICENSE NUMBER 29d. DATE, SIGNED (Month, Day, Year) | | | | | | | | | | | |
| 2 | | | | | | | | | | | | |
| - | 100 NORTH BROADWAY EMBRGENCY ROOM 31. DATE FILED (Month, Day, Your) . REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| | FEB 1 3 1996 | Jalia Davide | a-Rardall | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 96

| | | | | Certi | iticate of | Death | R | eg. No. | | |
|---|------------------|---|--|--|--|--|--|----------------------------------|-------------------------------------|---|
| Physic | an | Decedent's Neme (First, Middle, Last, CLARA MAE S | SMITH SWANN | | | | 2. Data of Dear | | Yeer 3. | Tima of Death |
| /Medi Examir | | 4a. Facility Name (If not Institution, give: | | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | 19:00 pi |
| LAGIIII | | 1306 W. LAF | | | | BALTIMO | DRE CIT | Y | n/a | |
| Funeral Director | | 5. Sociel Security Number 6. Sax 216-76-7888 | 7. Age (In yrs. les | | If Undar 1 Year Months Deys | | 8. Dete of Birth (Month, Day NOV. 7, 1 | 927 | 9. Birthplece Country) BALTIM | ORE, MD |
| the Maryland | tor | 10a. Stete 10b. County n/a | | Town or Loca BAI | TIMORE | CITY | | | | nside City Limits XXYas 2□ No |
| ith with the 23a or 28 unt be not | Funeral Director | 1306 W. LAFAYEE | Lafayette | Ave | 10f. Zip Code | 21217 | 1 | 0g. Citizen of V UNITE | What Country? | ATES |
| or items | ρ | 11. Marital Stetus 1 Never Merried AM Married 3 Widowed 4 Divorced | 12. Wes Decedant Evar in U,S. Armed Forces? 1 □ Yas X2X No If Yes, Give Yaar or Detes: | | is Decedent of I as, specify Cub | Hispanic Origin? (Sp san, Mexicen, Puarto Specify: | ecify Yes or No- Rican, atc.) | | e - American Ir ck, Whita, atc. | |
| "natural", | Completed | 15. Decedent's Edu (Specify only highest gred | cetion e com <i>pleted)</i> | 16a. Deceder (Give kir | nt's Usuel Occup nd of work dona | pation during most of work | ing | 16b. Kind of B | u siness/Ind ustr | у |
| Hygiene. ther than " ent, the Ma | dwo | Elamentery/Secondery (0-12) 9 th | College (1-4or 5+) | | NOT use retire SEWIFE | ∌d) | | DOMES | STIC i | n home |
| n and Mental Hygiene. Is marked other than raumatic event, the M | To Be C | 17. Father's Neme (First, Middle, Last) WILLIAM SMIT | 1 | | | 18. Mothar's Nam V I O | LWT WA | SHINGTO | Ν̈́ | |
| f Health and Mental Hygitem 27 is marked other other traumatic event, | | 19e. Informent's Neme/Reletionship (Ty MARIE SNIT | | 19b. Mailing 480 | Address (Street 7 CAL | t and Number or Rur UMET AV | E, BALTI | MORE, MI | Stete, Zip Coo 2120 | 6 |
| perint. reges I end z Depertment of Health a Important: If item 27 is any injury or other trai | | 20a. Method of Disposition 1 ☑ Kunel 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Othar (Specify) | emoval from State | ce of Disposit hatery, creme SHELL | lon (Neme of tory or other ple MEMOR I | | | 20c. Location - | OALK, M | |
| Depent Import any inj | | 21. Signeture of Fundatal Service License | 55 Jone | 22.1 | WM. C. | ess of Fecility march fh | 1101 | E. NOR | TH AVE | |
| | | 23a. Pert1. Enter the disease, or compli shock, or heaft feilure. List only or | cations that care ed the death. | Do not enter | tha mode of dyl | Ing, such es cerdiec | or respiratory arr | est, | App | proximata erval Between set and Deeth |
| nysician Medical | | Immediate Cause (Final disaase or condition | SCHEMIC | . C | ADDIA | MYNOAN | ₩ | | | 3485. |
| xaminer | - | resulting in deeth) | Due to (or e | es e conseque | ence of): | | | | | |
| ansit | Examiner | | CORONARY | Arro | | 15 ense | | | 1 | -OYRS. |
| physiclan and s the burial-transit | Exa | Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying | Dua to (or a | is a conseque | ince or). | | | | | |
| nding physic use as the b | /Medical | Ceuse (Disease or Injury that initiated events rasulting in deeth) Lest | Due to (or e | s e conseque | nce of): | | | | | |
| E - | | | | | | | | | | |
| ed by the etta detached for | Physician | Pert II. Other significant conditions con | tributing to death but not resulti | ing in the und | erlying ceuse gi | ven in Pert I. | | es 2 No | ntribute to the 3 Probably | cause of death? |
| 5.8 | by | | | | | | | 2010 | 7 | Z (|
| s been s 2 should | Completed | | | | | | 24e. Wes a perform | | availab | utopsy findings la prior to tion of ceuse n? |
| pertificate hes become pege 2 s | | | | | | | 1 🗆 Y | as 2 No | 1 ☐ Ya | s 2 No |
| certificate rector, pe | Be | 25. Was cese referred to medical exeminer? | ospitel: | | _ Ott | 26. Piece of Deat | 1 | | | |
| 18 | n: To | 27. Menner of Death | 1 □ Inpatient 2 □ EF | NOutpatient 8b. Time of | 3LI DOA | 4 Li Nursing no | ome 5.2 Reside | | | |
| (Table 1 | atio | 1 Naturel 5 ☐ Pending Invastigation | (Month, Day Year) | Injury | | ork?]Yes 2□No | | | | |
| al Dimete | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Plece of Injury - At hom building, etc. (Specify) | e, farm, stree | t, factory, office | | 28f. Location (Si City or Town | | per or Rural Ro | ite Number, |
| within 24 hours To the Funeral completery fille | edicai | 29a. Certifier (Check only one) Certifying Phys | ician: To the best of my knowle her: On the bests of examination and menner steted. | edge, death on and/or inves | ccurred et the ti stigation, in my c | me, dete end place, opinion, deeth occur | and due to the cred at the time, d | ause(s) and ma ate end plece, | anner as stated end due to the | ceuse(s) |
| within 24 noun To the Funeral completely filled | Σ | 29b. Signeture end title of certifier Syn h. No. | m. m.l. | | 29c. Licans | 17346 | | 9d. Data signe | 12/9 | Year) |
| 2 | | 30. Name and ederess of person who co | | 3e) (Type, Pr | int) | 1 | ß | | 100 = | |
| | | GEORGE W. MORIN | MD UNION | Mor | orin t | TOSPITITE, | DAT | MUSC | 10 2 | 1218 |
| Sta | te | 31. Dete in the Party Day 1996 | (1) 82. Rubistraris Sign Ch | 9 11 | | | | | | |



| 3OX 68760 BALTIMORE, MARYLAND 21215-0020 | or attending obselving |
|--|------------------------|
| AND 2 | boenital |
| RYL/ | ad by th |
| , MA | he retain |
| ORE | Б Шау |
| LTIM | ath Page |
| BA | after des |
| | hours |
| 30 | within 22 |
| 30X 68760 | ecuted |
| O | e be |
| m | 100 |

Pages 1, 2, 3 should

permit.

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medical examiner

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

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23

Aug

burial-transit the 38 use jo detached 2 page 5 should funeral director, completely filled in by the fall, cremation, or removal. cremation, or the traumatic event, inding physician and con Hygiene prior to burial, the attending physician Mental Hygiene prior to other t 10 Injury, FE Signed Health a shows has been s Dept. of H ATTENDING PHYSICIAN: The law 13 this certificate to with the State (b marked. A SE ,12 RECTOR / 28

DIVISION OF VITAL RECORDS, P.O.

Item1 2-13-96 FilmG732 W.H.Per F/H 96 03598 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH Ricky Antoino Summerville BABY ROY FEBRUARY 10,1996 5:19 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs, last birthday) 7. DATE OF BIRTH
(MONTH, DEV. WORL)
FEB. 10, 1996 IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign BALTIMORE, MD 1 M 2 F 56 YRS none 9e. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY MD n/a BALTIMORE 1 XYES 2 NO 10e, STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21213 UNITED STATES 1621 Ν. DURHAM STREET 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 🗡 Never Merried 2 🗌 Merried Specify: BLACK BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) H Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL BABY n/a none 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname RICKY SUMMERVILLE DANIELLE WILLIAMS 띪 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DURHAM STREET, BALTIMORE, MD 21213 PATRICIA WILLIAMS 1621 20e. METHOD OF DISPOSITION

1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State GREENMOUNT Place CREMATORY Donation 5 Other (Specify) 214 BALTIMORE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AE. K DRIL 23. PART t. Enter tha diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death disease or condition_ DUE TO (OR AS A CONSEQUENCE OP! Cardra asest resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate Immaturity at 61 1th cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO

| DID TOBACCO I | JSE CONT | RIBUTE TO CAUSE OF D | DEATH YES | NO UNCERTA | AIN 🗆 | 1 TES 2 NO | | | |
|---|----------|---|-----------------------------|----------------------|---|-----------------------|--|--|--|
| 25. WAS CASE REFERRED TO MEDICAL | | 26. F | PLACE OF DEATH (Che | ck only one) | | | | | |
| 1 YES 2 HO | | HOSPITAL: 1 D Inpatient 2 D ER/Outpatier | R 3 DOA 4 N | ce 8 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation | | 26e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | | | | | | |
| 3 Suicide 8 Could not be | | 28e. PLACE OF INJURY — A building, etc. (Specify) | it home, ferm, street, fe | actory, office | 28f. LOCATION (Street and Number of City or Town, State) | r Rurel Route Number, | | | |

29e. CERTIFIER

(Chack only

1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner se stated.

2 __ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CONTIFIED 29c. LICENSE NUMBER

| | 12nd | W | Juli | agli | er | | | | | |
|-----|----------|---------|----------|------|-----------|-------|----|-------------|-------|------|
| 30. | NAME AND | ADDRESS | OF PERSO | WHO | COMPLETED | CAUSE | OF | DEATH //TEM | 27) / | Oken |

| I | MIN | VDDHE22 | OF PER | SOM WHO CO | DMPLETED CAUSE | OF DEATH (ITEM 27 | (Type, Print) | |
|---|-----|---------|--------|------------|----------------|-------------------|---------------|---|
| | | ald | | | | 3000 | | - |

31. DATE FILED (Month, Day, Year, FEB 1 3 1996

A REGISTRAR'S SIGNATURE

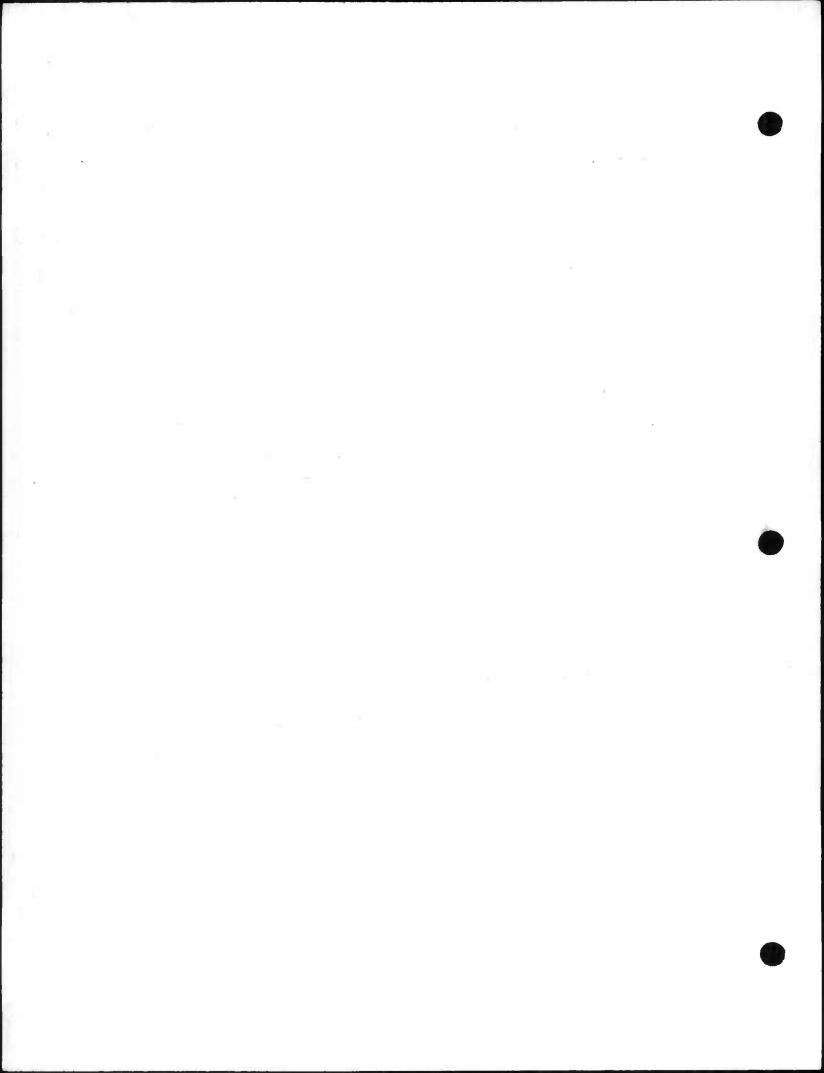
and of the second

FOR STATE OF MADVI AND / DEDARTMENT

| | 1 - STATE REGISTRAR | | C | ERTIF | ICAT | E OF | DEA | ГН | BEG | , NO. | | |
|--|---|---|--|--|---|---|--|-----------------------------|--|---|----------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | Bell SI | | | | | | 2. DATE OF DEA MONTH Februar | TH | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. I | | _ | R 1 YEAR | IF UNDER | 24 HRS. | T DATE OF DIST | *** | | 10:00 a. M |
| | 212-28-7569 | 1 🗆 M 2 💢 F | 83 | YAS. | MONTHS | DAYS | HOURS | MIN. | June 13 | 1912 | Country | |
| | 9e. FACILITY NAME (If not institution, give | street and number) | | | 9b. CIT | Y, TOWN C | PR LOCATI | ON OF DE | | | UNTY OF DE | |
| OR | 324 Wicklow Road | | | | | Glen | Burr | ie. | | | Anne | Arundel |
| מ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | | | I m I m | | | | | | | | |
| - DIRECTOR | Maryland | N/A | | 10c. CITY, TOWN OR LOCATION Baltim | | | | | Etimore | City | | 10d. INSIDE CITY LIMITS? 1 XES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | 4 | | | | 101 | . ZIP COD | | | | | HAT COUNTRY? |
| NE | 611 Rappolla Str | | | | | | 2122 | | | _ | tates | |
| | 1 Never Married 2 Merried | | T YES 2 | 2 NO If yes, specify Cuban, Mexican | | | | | n, Puerto Rican, el | fy Yee or No— c.) | 14. RACE Black | - American Indian, , White, etc. |
| B | 3 Widowed 4 Clyorced | WAR OR OATES | 1 YES 2 X NO Specify: | | | | | r. | | Specif | " White | |
| 0 | 15. DECEDENT'S EDU (Specify only highest grad | | DECEDENT'S | | | | | 18b. KIND C | F BUSINESS/IN | IDUSTRY | | |
| Ta l | Elementary/Secondary (0-12) | College (1-4 or 5 | | (Give kind at lie. Do NOT u | work done se retired.) | during mo | st of workir | g | | | | |
| MPI | 0 | | | Homen | nake | Z | | | 0 | wn Home | 2 | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOT | IER'S NA | ME (First, Middle, N | leiden Surneme) | | |
| B | George W. Mille | <u>t</u> | | | | | | | Bazzere | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | 1 | | | | | | Number, City | | | |
| | Mrs. Joan Der 324 Wicklow Road Glen Burnie, MD 21061 | | | | | | | | | | | |
| 20b. METHOD OF DISPOSITION 1 Devision Commettion Date Donastion Date Date 1 Donastion Donastion Date Date Date 20c. Location - City Donastion Date Date Date 20c. Location - City Date Date Date Date 20c. Location - City Date Date Date Date 20c. Location - City Date Date Date Date 20c. Location - City Date Date Date Date 20c. Location - City Date Date Date Date Date 20c. Location - City Date Date Date Date 20c. Location - City Date | | | | | | | | - City or Tov | vn, State | | | |
| 21. BICHATURE OF ECHIPPE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundal | | | | | | | | | | MU | | |
| | 1 (hal 1) | 2. 7 | The | | | Duc | la-Ru 22 Wi | ck f | uneral Ive. Du | Home of ndalk. | 6 Dun | dalk, Inc. 21222 |
| | 23. PART I. Enter the diseases, or abook, or heart fallure | complications the | nt couses the c | deeth. Do | not enter | the mo | de of dyl | ng, aucl | aa cardiac or | reepiratory as | rreat, | Approximate |
| | immediate Cause (Final | | | | | | | | | | | Interval Between Onset and Death |
| reaulting in death) a. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | RI | 1 21 | SEAS | E | |
| N | Sequentially list conditions | b | | | | Av | et 1 | RI | 1 PI | SEAS | E | |
| CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | b | OR AS A CONS | | | Ar | et ! | RI | 1 P) | SEAS | 3E | |
| IFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO | | EQUENCE O | F): | Ar | et ! | RI | 1 P) | SEAS | SE. | |
| ERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | b. DUE TO | (OR AS A CONSI | EQUENCE O | F): | Ar | et (| RI | 1 P) | SEAS | E | |
| L CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | OR AS A CONSI | EQUENCE O | F): | | | | | | | |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | bDUE TO | O (OR AS A CONSI | EQUENCE OF | F): | | | | Part I. 24a. W | IS AN AUTOPSY RFORMED? | 24b. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | bDUE TO | OR AS A CONSI | EQUENCE OF | F): | | | | Part I. 24a. W | AS AN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR COMPLETION OF CAUSE OF DEATH? |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DIABETE | b | OR AS A CONSI | EQUENCE OF resulting | F): | nderlying |) ceuse ç | lven in | Part I. 24a. W | IS AN AUTOPSY RFORMED? | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR OF CAUSE |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DIABETE DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | b | O (OR AS A CONSI | EQUENCE OF resulting | F): | nderlying |) ceuse ç | lven in | Part I. 24a. W | IS AN AUTOPSY RFORMED? | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR COMPLETION OF CAUSE OF DEATH? |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DIABETE DID TOBACCO USE CONT | b. DUE TO c. DUE TO d | O (OR AS A CONSIDER OF DEAL OF | reaulting ATH YE | F): In the use S | NO Only one) | UNC | ERTAIN | Part I. 24a. W | AS AN AUTOPSY RFORMED? ES 2 IMO | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR COMPLETION OF CAUSE OF DEATH? |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DIABETE DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | b. DUE TO c. DUE TO d | O (OR AS A CONSIDERATE OF DEAL | reaulting ATH YE ACE OF DEA: 3 □ DOA 28b. TIM | F): F): In the us TH (Check OTHEL 4 □ Nu E OF | NO Only one) R: sing Hom. 26c. INJ | UNC | ERTAIN | Part I. 24a. W | IS AN AUTOPSY RFORMED? ES 2 (1) NO | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural S Pending | b. DUE TO c. DUE TO d | O (OR AS A CONSIDERATE OF DEAL | reaulting ATH YE ACE OF DEA: 3 □ DOA 28b. TIM | F): In the us TH (Check OTHE 4 Nur | NO Only one) R: sing Home | UNC | ERTAIN | Part I. 24e. W PE 1 Y | IS AN AUTOPSY RFORMED? ES 2 (1) NO | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR COMPLETION OF CAUSE OF DEATH? |
| D BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 WHO 27. MANNER OF DEATH 1 Partural 5 Pending Investigation 3 Suicide 6 Could not be | b. DUE TO c. DUE YO d | OF INJURY — At h | reaulting ATH YE MCE OF DEA: 3 □ DOA 28b. TIM | F): In the use TH (Check OTHE 4 — Nur E OF URRY M | NO Only one) R: sling Homo 26c. INJI WOO 1 U | UNC S FA | ERTAIN | Part I. 24a, WP PE 1 Y Y Section (Specific 26d, DESCRIBE F. 25f, LOCATION (S. 25f, L | S AN AUTOPSY RFORMED? ES 2 INO | 24b. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| D BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | b. DUE TO c. DUE YO d | O (OR AS A CONSIDERATE OF DEAL OF DEAL OF DEAL OF DEAL OF DEAL OF DEAL OF DEAL OF DEAL OF THE DEAL OF | reaulting ATH YE MCE OF DEA: 3 □ DOA 28b. TIM | F): In the use TH (Check OTHE 4 — Nur E OF URRY M | NO Only one) R: sling Homo 26c. INJI WOO 1 U | UNC S FA | ERTAIN | Part I. 24e. W PE 1 Y 6 Other (Specify 26d. DESCRIBE F | S AN AUTOPSY RFORMED? ES 2 INO | 24b. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| D BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) | b. DUE TO c. DUE YO d | OF INJURY — At hete. (Specify) | resulting ATH YE ACE OF DEA 28b. TIM INJ NOME, form, 6 | F): In the use TH (Check OTHE 4 Num E OF UNY M street, fect | NO Only one) R: Sing Homo 26c. INJI WO 1 Y lory, office | UNC 5 FREDURY AT RECY ES 2 | ERTAIN sidence | Part I. 24a. WP PE 1 - Y 1 - Y 1 - Y 26d. DESCRIBE F 26d. DESCRIBE F 26f. LOCATION (S City or Town, | IS AN AUTOPSY RFORMED? ES 2 MO | 24b. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| D BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 HO 27. MANNER OF DEATH 1 Natural S Pending Investigation Suicide Could not be determined | b. DUE TO c. DUE TO d | deeth but not de | resulting ATH YE ACE OF DEA 28b. TIM INJ Goeth occurrent | F): In the use S | NO | UNC S FRED STATE S 2 and place, | ERTAIN sidence NO end due | Part I. 24a. We pe 1 U Y 6 U Other (Specify 26d. DESCRIBE For Town, 10 to the cause(e) en | AS AN AUTOPSY RFORMED? ES 2 MO IOW INJURY OC Stele) d manner ee sta | 24b. | WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| E COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) | b. DUE TO c. DUE TO d | deeth but not de | resulting ATH YE ACE OF DEA 28b. TIM INJ Goeth occurrent | F): In the use S | NO | UNC S FRO S FR | ERTAIN sidence NO end due | Part I. 24e. Will PE 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 | IS AN AUTOPSY RFORMED? ES 2 MO IOW INJURY OC Itreet and Number State) d manner ee state, and due to ti | 24b. CCURED or or Rural Ro | WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural S Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide determined 296. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 296. SIGNATURE AND TITLE OF CERTIFIE | b. DUE TO c. DUE TO d | O(OR AS A CONSIDER OF DEATH OF INJURY — At hetc. (Specify) | reaulting ATH YE ACE OF DEA 28b. TIM INJ Downe, farm, of the court | F): In the use SS Int (Check OTHEI 4 In Nur E OF UNY M street, fact ad at the t | NO | UNC 5 Page STREET From the control of the contro | ERTAIN sidence No end due | Part I. 24e. Will PE 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 | IS AN AUTOPSY RFORMED? ES 2 MO IOW INJURY OC Itreet and Number State) d manner ee state, and due to ti | 24b. CCURED or or Rural Ro | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Dute Number, end menner se stated. |
| E COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Ves 2 700 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | DUE TO C. DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 26e. DATE OF (Month, L. 28e. PLACE Of building, ICIAN: To the best of ear. ICIAN: To the best of ear. ICIAN: To the best of ear. ICIAN: To the best of ear. | O(OR AS A CONSIDER OF DEATH OF INJURY — At hetc. (Specify) | resulting ATH YE ACE OF DEA 28b. TIM INJ Country Investigation | F): In the use S | Only one) R: sing Homo 26c. INJI WO 1 | UNC 5 FRe URY AT RKY ES 2 end place, eath occur 29c. LICE | ERTAIN sidence No end due | Part I. 24e. W PE 1 Y 6 Other (Specify 26d. DESCRIBE F 26f. LOCATION (S City or Town, to the cause(e) en time, date end plet | IS AN AUTOPSY RFORMED? ES 2 MO IOW INJURY OC Itreet and Number State) d manner ee state, and due to ti | 24b. CCURED or or Rural Ro | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Dute Number, end menner se stated. |

FEB 1 3 1996

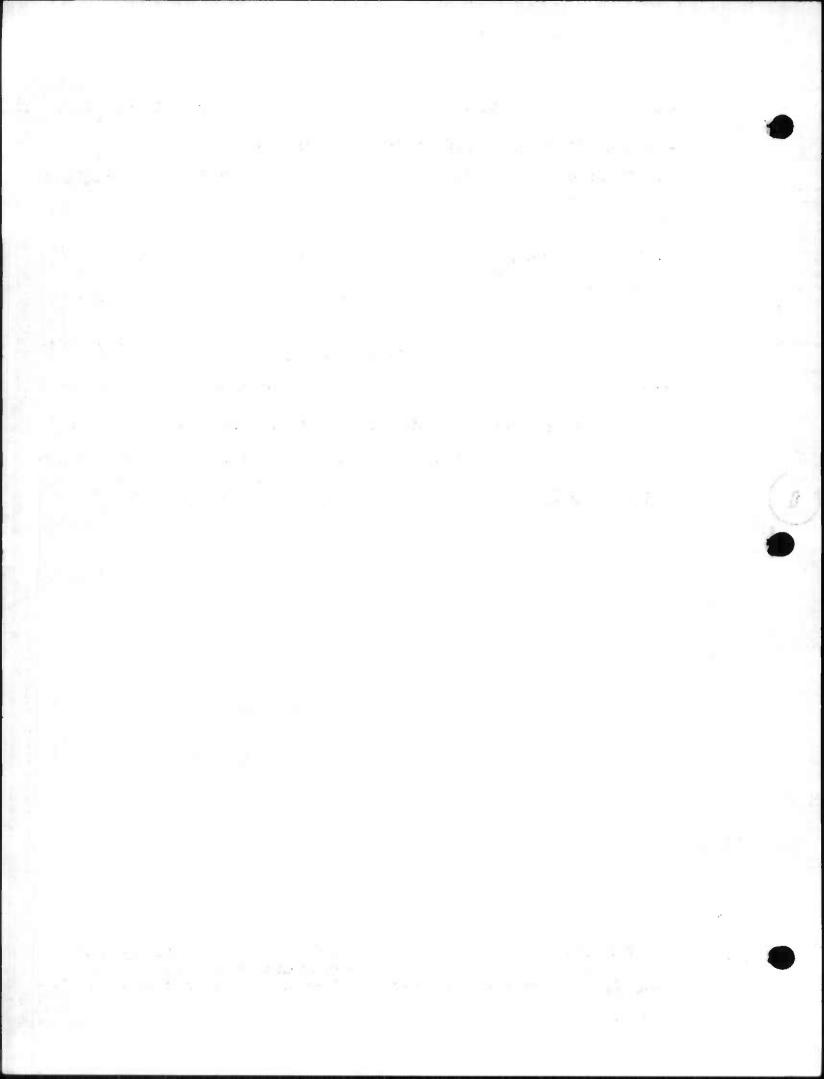
REGISTRAR SIGNATURE



State of Maryland / Department of Health and Mental Hygiene 96 03600

| | | | | | Cer | tificat | e of I | Death | | | Reg. No. | | | |
|--|----------------|--|---|-------------------------------------|---------------------|--------------------|---------------------|-------------------|-----------------|---------------------------------|-----------------------|---|--|----------|
| Dharis | | 1. Decedent's Nama (First, Middle, | Last) | | | | | | | 2. Dete of De Month | eath Day | Vanc | 3. Time of I | Death |
| Physici /Medio | | Charles L | • Sa | nson | | | | | | Februa | ary 11, | 1996 | 2:20 | pm |
| Examir | | 4a. Fecility Nama (If not institution, | rive street and number | er) | | | 4 | b. City, To | wn, or L | ocation of Deet | th 4c. Cour | ity of Deeth | | |
| | | Johns Hopkins B | Bayview Me | dical Ce | enter | | | Balt | imor | ·e | | | | |
| ıneral | | | . Sax 7. | Age (In yrs. lest t | | If Undar Months | 1 Yaar Deys | if Undar Hours | 24 Hrs. Min. | 8. Data of Bi (Month, Di | rth av. Year) | 9. Birth | piace (Stata or | Foreign |
| ector | | 234-70-7978 | 1 /2 M 2□ F | 50 | Yrs. | | Dojo | | 1771111 | 5/24/ | 45 | | rgini | |
| | | Usuei Residence of Decedant 10a. Stete 10b. County | | 10c. City, To | | antina | | | | | | | | |
| event, are received that the received as | 2 | MD 100. County | | Balt | | | | | | | | | 10d. Inside Cit 1 ☆ Yea | |
| | Director | | | Dalt | TINOL | 1 | | | | | | | | 2 110 |
| | | 10e. Street end Number | | | | 10f. Zip | | | | 1 | 10g. Citizen o | | ntry? | |
| | erai | 3519 Esther | | | 40.1 | | 212 | | 1.0.10 | | USA | | | |
| | Funeral | 11. Maritai Status 1 ☐ Never Married 2 ☑ Married | 12. Was Decede Armed Forca | is? | 13. V | Yas Deced | ent of H | n, Mexicar | n, Puerto | ecify Yas or No Rican, etc.) | | ace - Amari iack, White, | | |
| | by F | 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 If Yes, Give Yeer or Dete | | 1 | I □ Yes | 2 <mark>X</mark> No | Specify: | | | Spec | ily: Wh | ite | |
| | | 15. Decedent's | | | a Deced | lent's Usue | al Occurs | ation | | | 16b. Kind of | Rusiness/In | dustry | |
| | plet | (Specify only highast) | rade completed) | | (Give | kind of wo | rk done d | during mos | t of work | ing | | | | |
| | Completed | Elemantary/Secondery (0-12) | College (1-4d | | | | | t Cu | | | FOLE | Geor | ge Mea | age |
| | | 17. Fether's Nema (First, Middle, La | st) | 1 | | - ~ T | | | | | , Maiden Sum | eme) | | |
| | To Be | Harry E. Sans | on | | | | | | | Notti | | | | |
| | - | 19e. informent's Neme/Relationship | (Time Driet) | | 9b. Meilin | g Address | | | | | per, City or Tow | m, Stete Zi | o Code) | |
| | | Clydetta (Jud | W. | rre | | - | - | | | | nore, | | | |
| | | 20e. Method of Disposition | ly / Salisoi | 20b. Place | of Dispos | sition (Ner | ne of | | - | Data | 20c. Location | | | |
| | | 1⊠ Buriel 2 □ Cremetion 3 | | Dula: | | Val | | Θ) | 12 | /15/9 | 6 Bal | | | ntv |
| - | | 4 □ Donetion 5 □ Othar (Special Signature of Funaral Service Lice | | 2 11 2 01 | | | | o of English | | | | | | |
| once. | | 21. Significate of Fullaral Service Lic | 911598 | 1 | | | | | | | . Zanı | | | |
| | | Maria D. | Spaner | 4 | | _ | | | | | alto. | Ma. | 21224 | |
| | Ш | 23a. Part1. Enter the disease, or shock, or haert failure. List | polications that cause on each | sed the deeth. Do h iina. | o not anta | ar tha mod | a of dyin | g, such as | cardiac | or respiratory e | errest, | | Approximete intarval Betw | reen |
| n | | Immediate Cours (First | | | | | | | | | | 1 | Onset and D | eatri |
| al er | | immediate Couse (Fine) disease or condition resulting in death) | Intrace | rebral h | emor | rhage | € | | | | | 1 | 22 F | 45 |
| | ایرا | Tooling it duality | | Dua to (or as | a conseq | uence of): | | | | | | | | |
| | i i | | Hyperte | nsion | | | | | | | | - 1 | 22 1 | 1/3 |
| | Examiner | Sequentially list conditions, if any, leading to immadiate | | Due to (or es | a conseq | uenca of): | | | | | | ! | | |
| | a E | cause. Enter Underlying Ceuse (Diseese or injury that initieted events | c | | | | | | | | | ì | | |
| | edical | that initieted events rasulting in deeth) Last | | Due to (or es a | consequ | uence of): | | | | | | | | |
| | ₹ | | d | | | | | | | | | | | |
| | lan | - | | | | | | | | | | 1 | | |
| | Physician | Part ii. Other algnificant conditions | contributing to death | but not rasulting | in the ur | nderlying c | ause giv | en in Pert i | i. | 23b. Dld | tobacco une | contribute t | o the cause of | f death? |
| | | | | | | | | | | 1 🗆 | Yes 2 No | 3 □ Pro | bably 4 Kil | Jnknown |
| | d by | | | · | | | | | | 04: 141 | roc organity | 24h 18 | loro autono, fi- | ndines |
| | Completed | | | | | | | | | | s an autopsy omed? | 81 | fere autopsy fir vailable prior to empletion of ca |) |
| | npl | | | | | | | | | | | of | daath? | |
| | S | | | | | | | | | 12 | Yes 2□No | 1 | □Yes 2101 | No |
| | Be | 25. Was case referred to medical examiner? | 11000U | | | | | | of Deet | h (Check only | one) | | | |
| | 2 | 1 ☐ Yes 2 🛣 No | Hospitai: | atlent 2 ER/C | Outpatien | | | 4 L N | ursing Ho | me 5 Res | Idence 6 🗆 C | thar (Speci | fy) | |
| | | 27. Manner of Deeth 14 Naturel 5 ☐ Pending | 26a. Dete of Ir (Month, I | njury 28b Dey Year) | . Time of Injury | 2 | 8c. Injun Worl | at k? | | 28d. Dascribe | how injury occ | urred | | |
| | Certification: | 2 ☐ Accident investiget | on | | | М | | Yes 2□ | No | | | | | |
| | ₩ F | 3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicide detarmine | A Zoa. Placa of | injury - At home, etc. (Specify) | farm, stre | et, fectory | , office | | | 28f. Location (| (Street end Nui | nber or Run | ai Route Numb | oer, |
| | Ce | | | | | | | | | | | | | |
| | cai | 29a. Certifler (Check only 2 ☐ Medical Ex | Physician: To the bes | st of my knowledg | ge, deeth | occurred | et the tim | ne, deta en | d plece, | and dua to tha | causa(s) and | mannar as s | stated. | |
| | Medical | one) | end menner | stated. | A INVOLUTE | | | | ar occur | oo or me time, | | | | |
| | 2 | 29b. Signeture end title of certifier | | | | | | number | | | 29d. Data sign | ned (Month, | Day, Year) | |
| | | Lodd Cap | | | | 9 | 6015 | | | | Febru | ary 1 | 2,1996 | |
| - | | 30. Nama and eddress of person wh | o complated cause o | f deeth (Item 23e |) (Type, I | Print) J | ohns | Hopk | ins | Bayviev | w Medic | the set of | | |
| | | Toold Cox - : | Johns Hop | kin Bay | vien | 1 | | _ | | | Baltim | | | 224 |
| Sta | te | 31. Deta filed (Month, Day, Year) | | strer's Signatura | | | | | | | | | | |
| gistr | | FEB 1 3 1996 | Jalia d'austes | rhadell | | | | | | | | | | |
| | | | | | | | | | | | | | | |

DHMH 16 Ray 6/95

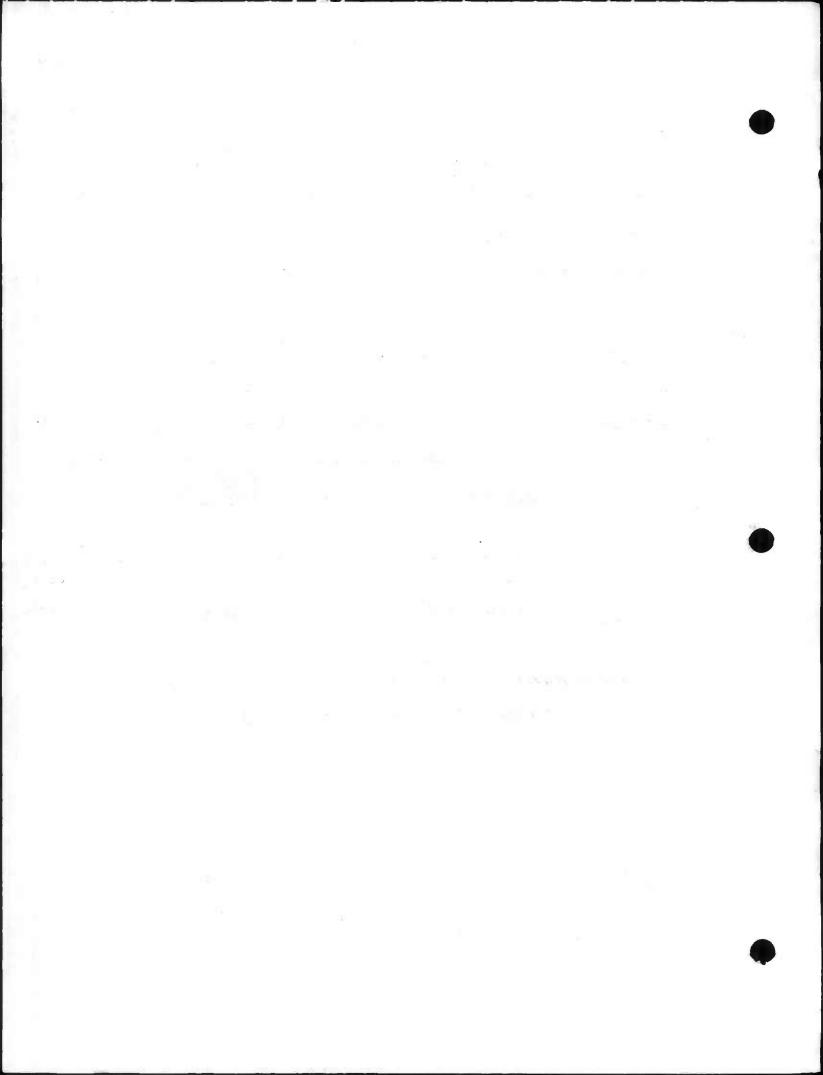


DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OF ATTEMPT PHYSICIAN: The law requires that the death certificate be executed with TO THE HURFALL DIVISION OF VITAL BY SECOND TO THE HURFALL DIVISION AND THE HURFALL DIVISION TO THE HURF

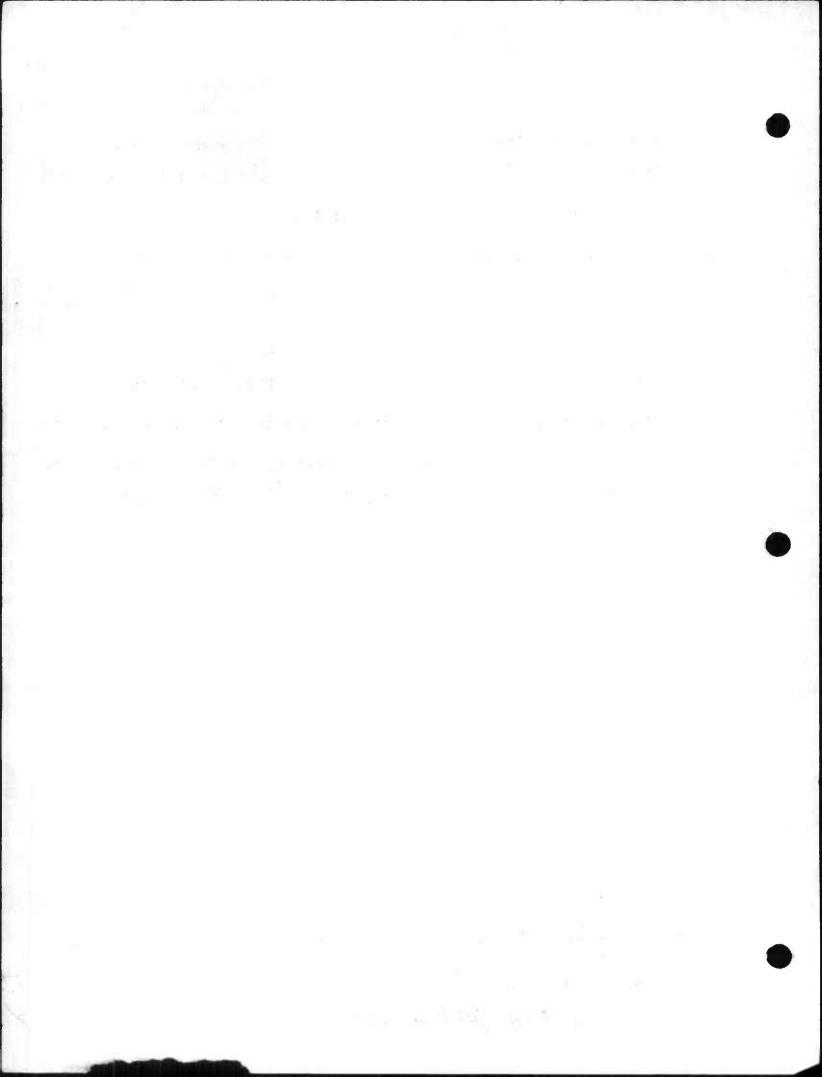
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF I | | MENTAL HYGIENE REG. NO. | | | | | | | |
|---------------|---|---|--|-------------------------------------|------------------------|--|-------------------|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | .2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | |
| | NATHANIEL SHE | AR | | | | February 8 | 1996 | 10:10 A M | | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | HPLACE (State or Foreign | | | | | |
| | 226-42-5964 9a. FACILITY NAME (If not institution, give: | t K M 2 □ F 8 | 7 YRS. | MONTHS DAYS | HOURS MIN. | Dec. 20, 19 | 908 New | York | | | | | |
| OR | Hebrew Home Of Gr | | gton | Rockvi | OR LOCATION OF DI | EATH | Montgo | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | | | TOWN OR LOCA | | | | | | | | | |
| E E | | | 272 | | | | 10d. INSIDE | | | | | | |
| | Maryland Mo | ntgomery | R | ockvill | f. ZIP CODE | | 10- CITIZEN OF | t X YES 2 NO | | | | | |
| RA | 6121 Montrose Roa | A | | " | 20852 | | | | | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | IN U.S. ARMED | 13. WAS DE | | NIC ORIGIN? (Specify Yes | U.S. | A . CE — American Indian, | | | | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | | ecify Cuban, Maxica 2XXNO Specif | n, Puerto Rican, atc.) | Bla | ck, White, atc. | | | | | | |
| ВУ | 3 Widowed 4XXDivorced | | | 1 | | ,. | 4 | White | | | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | ICATION 5 completed) | 16a. DECEDENT'S L | ork done during m | ON ost of working | 16b. KIND OF BUSI | NESS/INDUSTRY | | | | | | |
| E | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | | | | | | | | | | |
| M | 17. FATHER'S NAME (First, Middle, Last) | 5+ | Physici | st | | | vernmer | nt | | | | | |
| | | | ME (First, Middle, Malden S tta Robinso | | | | | | | | | | |
| BE | Victor J. Shear | | Route Number, City or Town, | | | | | | | | | | |
| 2 | Marie Hayes | | | | | ilver Sprin | | 1 and 20901 | | | | | |
| | 20a. METHOD OF DISPOSITION | 200 | | _ | | | ATION - City or | | | | | | |
| | 1 K Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) | noval from State | b.PLACE AND DATE OF THE BERT O | er plece) | 2/09/ | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | odiic iicbi | | | | INERAL I | New York HOME, INC. | | | | | |
| | Donald C. | Stattle | nyer | 232 | ARROLL S | TREET N.W. | 2095 | ioni, ino. | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, ehock, or heart fellure. Liet only one cause on each line. Approximate interval Between | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events ARTERIDSCLEROTIC CEREBROVASCULAR DISEAS 3 YEARS | | | | | | | | | | | | |
| H | resulting in death) LAST | d | | | | | | | | | | | |
| MEDICAL O | PART II. Other algorificent condition | | | | g ceuse given in | Pert I. 24a. WAS AN / PERFORM | AED? | b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| Σ | DID TOBACCO USE (| CONTRIBUTE TO | CALISE OF | DEATH V | ES CO NO | 57 | | 1 YES 2 NO | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | DOMINIBOLE 10 | CAUSE OF | | LACE OF DEATH (CA | | | | | | | | |
| Sic | EXAMINER? | HOSPITAL: | | OTHER: | | 8 ☐ Other (Specify) | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 26a. DATE OF INJURY | 28b. TIME | OF 28c. IN | JURY AT | 26d. DESCRIBE HOW IN | JURY OCCURED | | | | | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJU | | ORK? YES 2 NO | | | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, atc. (Spe | Y — At home, farm, at | reel, fectory, offi | on . | 261. LOCATION (Street ar City or Yown, State) | nd Number or Rura | Route Number, | | | | | |
| 91 | 29a. CERTIFIER DECERTIFYING DAYS | SICIAN: To the heat of our have | ulada a dandha a a a a | | | | | | | | | | |
| COMPLETED | | SICIAN: To the best of my know ER: On the basis of examination | | | | | | (s) and manner as stated. | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | P Land | MIT | > | 29c. LICENSE NUI | MBER | 29d. DATE SIGNE | ED (Month, Day, Year) | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | O COMPLETED CALISE OF DI | EATH (ITEM 27) (Time | Print) | V O: | 2885 | 1/8 | 76 | | | | | |
| | STEVEN L | IPSON | | | ROSE | ROAD, | ROCK | VICLE, AD | | | | | |
| | FEB 1 3 1996 | 32 REGISTRAR'S SIGN | NATURE | | | | | - / 12 | | | | | |
| | 1 FDT 0 1330 4 | No or the state of the state of | | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O.C.

| | 1 -3 | 1. Decedant's Nama | (First Middle La | ast) | | | | | | 2. Data of De | Reg. No. | | 3. Time o | d Dooth |
|---|--|--|--|--|--|--|--|--|---------------------------|---|--|--|---|--------------------------------|
| Physici | ian | | | | | | | | | Month | Day | Yaar | | 2 6 |
| /Medi | | | ANNE | SMIT | | | | | | JANUARY | . 1 | 996 | 15 | |
| Examir | ner | 4a. Facility Name (If | - 16.21/1 | | er) | | | 4b. City, | Town, or L | ocation of Dea | th 4c. Count | y of Death | | |
| | . 1 | University Hospital | | | | | | | Balt | imore | | n/a | | |
| Funeral | | 5. Social Sacurity No | 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last | | | | If Under 1 Yas | | der 24 Hrs. | 8. Date of Bi (Month, D | | | olace (Stata | or Fore |
| Director | | 218-64- Usual Residence of | -4215 | 1□M 2/2 F | 42 | Yrs. | MONTS Day | ys Hour | S IVIII. | Oct.9 | | | rylar | |
| B m | | 10a. Stata | 10b. County | | 10c. Cit | y, Town or Loca | ation | | | | | 1 | Od. Inside C | ity Lim |
| 28a-f show notified at | ctor | Md/ | n/a | | | | Balt | imor | e. | | | | Yes | 20 |
| a or 28 De no | Director | 10a. Street and Num | | | | | 10f. Zlp Code | | | | 10g. Citizen of | What Coul | ntry? | |
| 22 | sra | | Boston | Street | | | | | .224 | | | SA | | |
| r, or items xaminer m | by Funeral | 11. Marital Status 1 Navar Marrie 3 Widowed | | 12. Was Decede Armed Force 1 Yas 2 If Yes, Give Year or Date | es? 23 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Ricen, atc 1 □ Yas 2 No Specify: | | | | Speci | ce - Amark ick, White, fy: Tall | | |
| 55 | | | | | 75. | 10. D | ede He in One | - At | | | | | | |
| n "nat | Completed | (Speci | 15. Decedent's E- ify only highest great | ducetion ede completed) College (1-4) | or 5.1\ | 16a. Decede (Give ki | int's Usual Occ ind of work dor O NOT use reti | cupation ne during m ired) | nost of work | ing | 16b. Kind of E | Business/Industry | | |
| The Man | E | 12t | | Conege (1-4) | or St) | Compi | uter F | roar | amer | | Ra | ilro | be | |
| other rent, 1 | 0 | | | 1) | | | | | | | | | 20 | |
| | o Be | 17. Father's Name (First, Middla, Last) Charles W. Smith 18. Mother's Name (First, Middle, Meiden Surnem Eleanor Birdson | | | | | | | | | | | | |
| and Ments is marked sumatic e | L L | 19a. Informant's Na | me/Relationship (| (Type, Print) | | 19b. Mailing | Address (Stre | eet end Nur | | | per, City or Town | | Code) | |
| ment of Health ant: If Item 27 ury or other to | | Eleano | or Smit | h | | 7815 | 5 Marnh | rook | Pon | d Do 14 | imama | Mal | 2122 | 1 |
| | | 20a. Mathod of Disp | | ** | 20b. P | Place of Disposi | ition (Name of | | . KOa | Date | imore 20c. Location | | | 4_ |
| | | Buriai 2 | | Removal from Sta | 110 | emetery, crems | | | h | | | | | |
| marker of | | 21. Signatura of Fun | | | no | | ill Ce | | | /1/96 | Bali | cimor | ce Md | |
| hysician | | 0 | - 1 | 16 | 1 | Co | 222011 | 77 E 11 | nora | 1 110m | 0.5 E | | | |
| | | 15 | Lerr | M Con | mill | 41 30 | JU Wac | y ru | nera | I HOME | of Es | ssex | 221 | |
| | | 23a. Part1. Enter the | e diseese, or com | plications that cau | sad the deat | - | JU Hac | | | | | | /-/-1 | 10 |
| | | SHOOK, OF HEAT | tianulo. List offit | | h line | n. De not enter | the mode of d | lying, such | as cardiac | or respiratory | arrast, | | Approxima | 16 |
| | | | | enercause on each | h line. | n. De not enter | the mode of d | lying, such | as cardiac | or respiratory | ore Md | | Approxima Interval Be Onset and | tweer Death |
| Medical | | Immediate Cause (F | Final | Ni. | , | | | | as cardiac | or respiratory | irrast, | | Approxima Interval Be Onset and | tweer Deatl |
| | | Immediate Cause (F disease or condition resulting in death) | Final | Ni. | BRAL | HERN | INTWI | | as cardiac | or respiratory | arrast, | | Approxima Interval Be Onset and | tweer Deati |
| Medical | 16 | disease or condition | Final | a CERE | B N AL Due to (o | HERN or as a conseque | ence of): | 2 | as cardiac | or respiratory | arrast, | | Onset and | tweer Death |
| Medical xaminer | niner | disease or condition | Final | Ni. | B N AL Due to (o | HERN or as a conseque | ence of): | 2 | as cardiac | or respiratory | arrast, | | Onset and | tweer Deat |
| Medical xaminer | caminer | disease or condition resulting in death) | Final | a CERE | BRAL Due to (o | HERN or as a conseque | once ot): | 2 | as cardiac | or respiratory | arrast, 110 | | Onset and | tweer Deat |
| Medical xaminer | Examiner | disease or condition resulting in death) | Final | a. CERE | Due to (o | HERN or as a consequent or as a consequent or as a consequent | ence of): | 2 | as cardiac | or respiratory | arrast, 110 | | Onset and | tweer Deat |
| Medical xaminer | icai Examiner | disease or condition resulting In death) Sequentially list confidence in any, leading to improve. Enter Under Cause (Disease or lithet Initiated events | Final niditions, mediate thying njury | a. CERE | BRAL Due to (o ACHNO Due to (o | HERA or as a consequing or as e consequing ANEU | ence of): MORRH ence of): | 2 | as cardiac | or respiratory | arrast, 110 | | Onset and | tweer Deat |
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| the this certificate has been signed by the ettending physician and pointeral director, page 2 should be deteched for use as the buriel-transit | To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list conif any, leading to immoves. Enter Under Cause (Disease or in that initiated events resulting in death) L. Part II. Other significations of the control o | inditions, mediate hybrid sest cant conditions of the conditions | a. CERE b. SJB 772 c. CONO d. ——————————————————————————————————— | Due to (or Due to | HERNOr as a conseque ANGU Tas a conseque ANGU Tas a conseque ER/Outpatient 28b. Time of Injury Date of term, street | ence of): NORTH ence of): NYSM ence of): DOA 28c. In W 1 | givan In Pa 26. Pli Other: 4 July et Vork? Vork? | ace of Deat Nursing Ho | 23b. Dld 1 | tobacco use collives 2 No san autopsy ormad? Yas 2 No one) Idence 6 Other how injury occur. | 24b. Way oo of | o the cause bably 4 ere autopsy allable prior mpletion of death? Yes 2 | of de |
| the this certificate has been signed by the ettending physician and pointeral director, page 2 should be deteched for use as the buriel-transit | To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list conif any, leading to introduce. Enter Under Cause (Disease or in that initiated events resulting in death) L. Part II. Other signification of the content | ed to medicel S Pending Investigation 6 Could not b | a. CERE b. SJB 772 c. CONO d. ——————————————————————————————————— | Due to (or Due to | HERNOr as a conseque ANGU Tas a conseque ANGU Tas a conseque ER/Outpatient 28b. Time of Injury Date of term, street | ence of): NORTH ence of): NYSM ence of): DOA 28c. In W 1 | givan In Pa 26. Pli Other: 4 July et Vork? Vork? | ace of Deat Nursing Ho | 23b. Dld 1 | tobacco use co | 24b. Way oo of | o the cause bably 4 ere autopsy allable prior mpletion of death? Yes 2 | of de |
| the this certificate has been signed by the ettending physician and pointeral director, page 2 should be deteched for use as the buriel-transit | To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list conif any, leading to introduce. Enter Under Cause (Disease or in that initiated events resulting in death) L. Part II. Other signification of the conference of the co | ed to medical S Pending Investigation Could not be determined | a. CERE b. SJB M2 c. COND d | Due to (or Due to | HERVOutpatient 28b. Time of Injury wiedge, death of winds a consequence of the conseque | ence ot): \(\lambda \colon \ | givan In Pa 26. Ph Other: 4 ijury et vork? Yes 2 | ace of Deat Nursing Ho | 23b. Did 1 1 24a. Wat perf 1 1 Res 28d. Describe 28f. Location City or To | tobacco use colling to the san autopsy ormad? Yas 2 No one) idence 6 Other how injury occur (Street and Number), State) | pontribute to 3 Pro 24b. W av co of 1 [ther (Special rised ber or Rura anner es s | tated. | of de Junka findin 10 cause No |
| the this certificate has been signed by the ettending physician and pointeral director, page 2 should be deteched for use as the buriel-transit | edical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list con if any, leading to immove the cause (Disease or in that initiated events resulting in death) L. Part II. Other signification of Death 1 Per 2 Per 2 Per 2 Per 3 Per 3 Per 4 Per | ed to medical Solutions of the second state o | a. CERE b. SJB 772 c. CONG d. Contributing to death contributing to death contributing to death contributing to death contributing to death contributing to death contributing to death | Due to (or Due to | HERVOutpatient 28b. Time of Injury wiedge, death of winds a consequence of the conseque | ence of): O.2.N.H. ence of): DOA derlying ceuse 3 □ DOA M 1 at, factory, office Docurred at the stigation, in my | givan in Pa 26. Pli Other: 4 Jordan Vork? Vork? Ves 2 | ace of Deat Nursing Ho | 23b. Did 1 1 24a. Wat perf 1 1 Res 28d. Describe 28f. Location City or To | tobacco use co | 24b. Way oo of 1[| or the cause bably 4 or autopsy allable prior impletion of death? Yes 2 or all Route Number 1 or the cause (or the cause) | of de Junka findin 10 cause No |
| the this certificate has been signed by the ettending physician and pointeral director, page 2 should be deteched for use as the buriel-transit | To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list conif any, leading to introduce. Enter Under Cause (Disease or in that initiated events resulting in death) L. Part II. Other signification of the conference of the co | ed to medical Solutions of the second state o | a. CERE b. SJB M2 c. COND d | Due to (or Due to | HERVOutpatient 28b. Time of Injury wiedge, death of winds a consequence of the conseque | ence of): O.2.0 H/ ence of): DOA derlying ceuse 3 DOA M 1 28c. In What, factory, office coccurred at the stigation, in my 29c. Lica | givan in Pa 26. Pli Other: 4 Jordan Vork? Vork? Vork? Vork opinion, coans a numbing a numbin | ace of Deat Nursing Ho | 23b. Did 1 1 24a. Wat perf 1 1 Res 28d. Describe 28f. Location City or To | tobacco use colling to the san autopsy ormad? Yas 2 No one) idence 6 Other how injury occur (Street and Number), State) | 24b. Way oo of 1[| or the cause bably 4 or autopsy allable prior impletion of death? Yes 2 or all Route Number 1 or the cause (or the cause) | of de Junka findin 10 cause No |
| this certificate has been signed by the ettending physician and Decipies at director, page 2 should be deteched for use as the buriel-transit | edical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list con if any, leading to immove the cause (Disease or in that initiated events resulting in death) L. Part II. Other signification of Death 1 Per 2 Per 2 Per 2 Per 3 Per 3 Per 4 Per | ed to medical Solutions of the second state o | a. CERE b. SJB 702 c. CONO d. contributing to death contributing to death contributing to death contributing to death contributing to death contributing to death contributing to death contributing to death contributing to death | Due to (or Due to | HERVOutpatient 28b. Time of Injury wiedge, death of winds a consequence of the conseque | ence of): O.2.0 H/ ence of): DOA derlying ceuse 3 DOA M 1 28c. In What, factory, office coccurred at the stigation, in my 29c. Lica | givan in Pa 26. Pli Other: 4 Jordan Vork? Vork? Ves 2 | ace of Deat Nursing Ho | 23b. Did 1 1 24a. Wat perf 1 1 Res 28d. Describe 28f. Location City or To | tobacco use co | 24b. Way oo of 1[| or the cause bably 4 or autopsy allable prior impletion of death? Yes 2 or all Route Number 1 or the cause (or the cause) | of de Junka findin 10 cause No |
| the this certificate has been signed by the ettending physician and pointeral director, page 2 should be deteched for use as the buriel-transit | edical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list con if any, leading to immoves. Enter Under Cause (Disease or in that initiated events resulting in death) L. Part II. Other signification of the initiated events resulting in death) L. Part III. Other signification of the initiated events resulting in death) L. Part III. Other signification of the initiated events resulting in death) L. 25. Was cese referred exeminer? 1 Yes 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and the initiated exemples one) | ed to medical Solutions, mediate tying njury lest cant conditions of the condition | a. CERE b. SJB M2 c. CONO d. Contributing to death contributing to death 28e. Detail (Month, in the basis and manner) | Due to (or Due to | HEROUTE AND THE PROPERTY OF TH | ence of): O.2.17 H // ence of): O.2.17 H // ence of): DOA 0 28c. In | givan In Pa 26. Pi Other: 4 — jury et Vork? — Yes 2 ee stime, date y opinion, co | ace of Deat Nursing Ho | 23b. Did 1 1 24a. Wat perf 1 1 Res 28d. Describe 28f. Location City or To | tobacco use colling to the san autopsy ormad? Yas 2 No one) idence 6 Other to the sand Numeron, State) cause(s) and mandate end piece 29d. Date sign | pontribute to 3 Pro 24b. Way occ of 1[ther (Specifirred ber or Rura anner es s. end due to end d | or the cause beby 4 allable prior impletion of death? Yes 2 (y) Italed. or the cause (| of de Junka findin 10 cause No |
| the this certificate has been signed by the ettending physician and pointeral director, page 2 should be deteched for use as the buriel-transit | edical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list con if any, leading to immove the cause (Disease or in that initiated events resulting in death) L. Part II. Other signification of Death 1 Per 2 Per 2 Per 2 Per 3 Per 3 Per 4 Per | ed to medical Solutions of the second secon | a. CERE b. SJB M2 c. CONO d. Contributing to death contributing to death 28e. Detail (Month, in the basis and manner) | Due to (or Due to | HEROUTE AND THE PROPERTY OF TH | ence of): O.2.17 H ence of): O.2.17 H ence of): Deriving ceuse 3 DOA 28c. In 12 and 12 an | givan In Pa 26. Pi Other: 4 — jury et Vork? — Yes 2 ee stime, date y opinion, co | ace of Deat Nursing Ho | 23b. Did 1 1 24a. Wat perf 1 1 Res 28d. Describe 28f. Location City or To | tobacco use co | pontribute to 3 Pro 24b. Way occ of 1[ther (Specifirred ber or Rura anner es s. end due to end d | or the cause beby 4 allable prior impletion of death? Yes 2 (y) Italed. or the cause (| of de |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

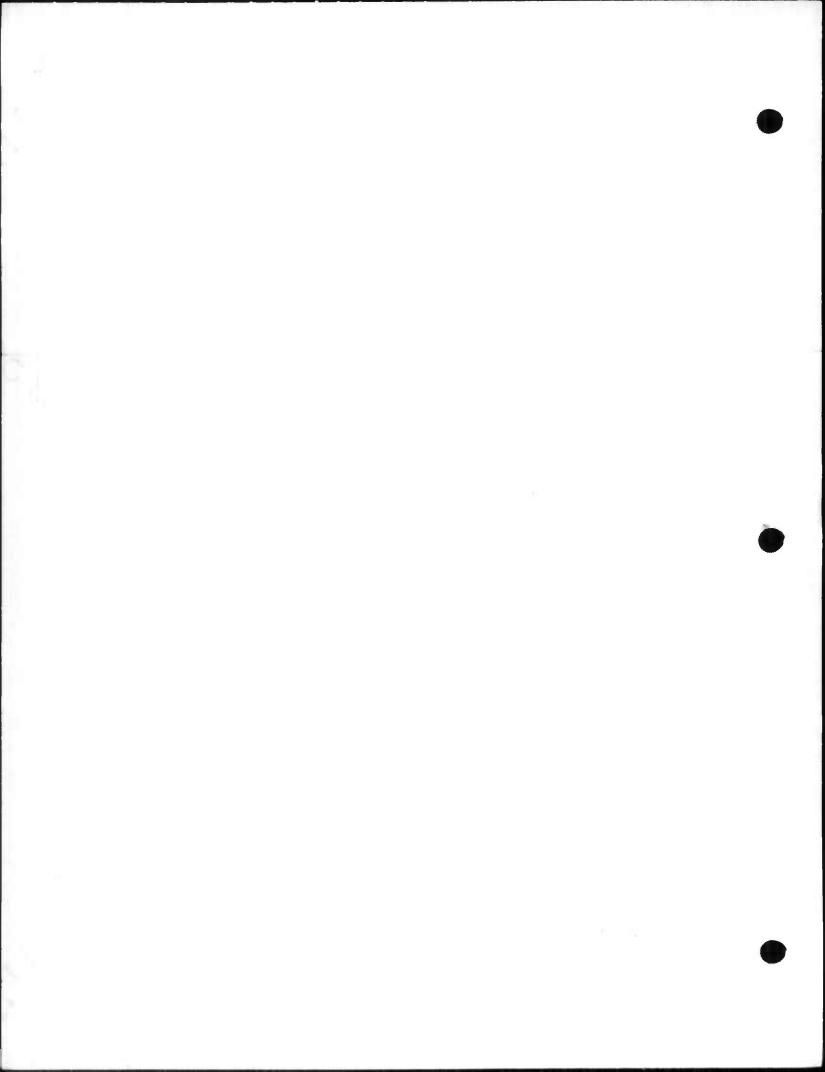
BALTMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

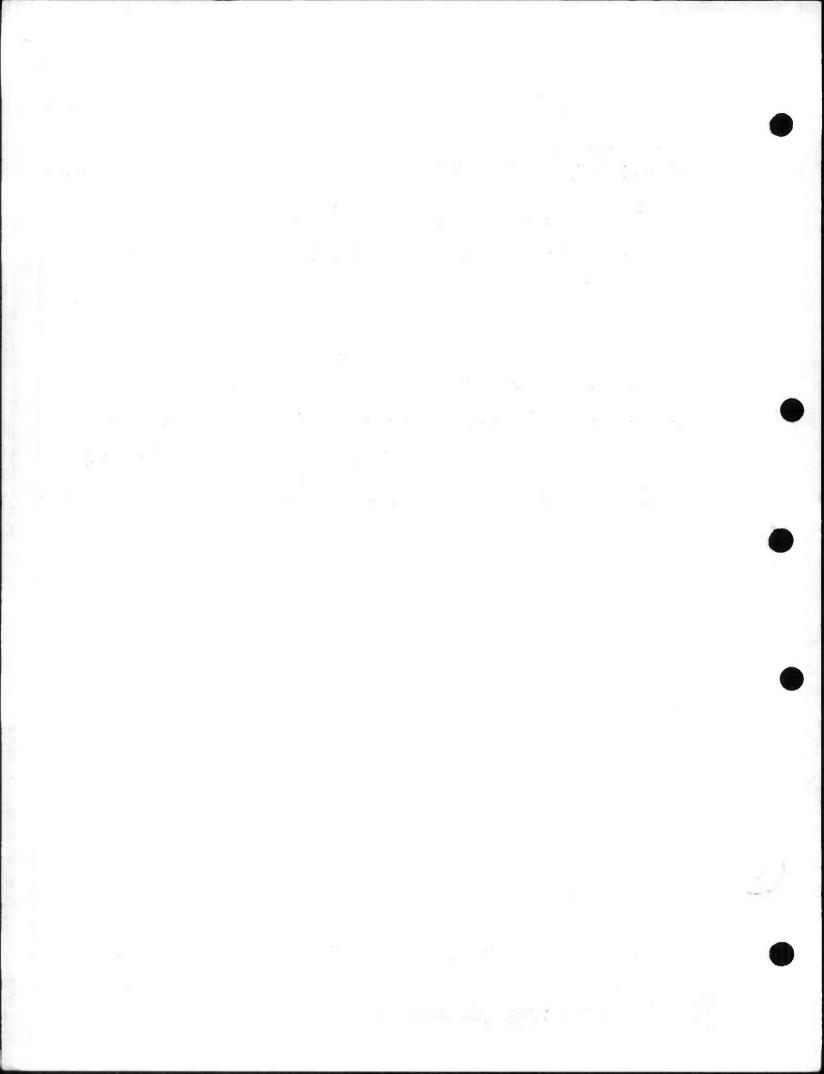
| | HEGISTHAH | | CEI | KIIFI | CALE OF | DEATH | | REG. NO | | | |
|------------------|---|---|-------------------------------------|---|-----------------------------|-------------------------------|------------------------|---|-----------|----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) TOSIE | D. | SPE | AK | | | 2. DATE OF | F DEATH D | N 8- 10 | 796° | 3. TIME OF DEATH 7:30 A M |
| | 400-60-0910 | 1 □ M 2 🏋 F | AGE (In yrs. last b | | IF UNDER 1 YEAR MONTHS DAYS | # UNDER 24 HRS. HOURS MIN. | June | 24, 1 | 911 | 8. BIRTH Country Wes | PLACE (State or Foreign V Virgini |
| TOR | 90. FACILITY NAME (If not institution, give street Maridian Nursing RESIDENCE OF DECEDENT | | nsvill | | | on Location of I | | | | nty of Di ltin | |
| FUNERAL DIRECTOR | Maryland Balt: | imore | | | nsdowr | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| ERAL | 10o. STREET AND NUMBER 3148 Reyerson (| Circle | | | 101 | 21227 | | | | | MAT COUNTRY? States |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR | YES 2- NO | I.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN 11 yes, specify Cuban, Maxican, Puerto F | | | | RIGIN? (Specify Yea or No.— 14. RACE Black, Specify | | | — American Indian, White, etc. |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) | (Glve | DENT'S U kind of wo o NOT use | ISUAL OCCUPATION ork done during more retired.) | ON est of working | 16b. K | IND OF BU | SINESS/INC | DUSTRY | WIII | |
| M | 1.2 | | ho | men | aker | | | wn h | | | |
| BE CC | Mitchel Speak | | | | | Eliza | | | - ' | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | nd Number or Rura | | | | | 21227 |
| | Fred Lee, nephe | | | | Reyers | _ | cle I | | | e, Ma | rylaND |
| | 4 Denetion 5 Other (Specify) 21. SIGNATURE OF THE TALL SERVICE LICET | | GeTeen H | la ve | MacCeme | tery | 2/12 | G16 | en B | urni | e,Marylan |
| | All book | Hammon | eral ds Fe | rry | Roa | d 2 | sdowne | | | | |
| | 23. PART I. Enter the diseases, or conshock, or heart feliure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) | ACUTE | on each lina. | BRO | VASCU | | | | | reat, | Approximata interval Between Onset and Daeth |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): ACTERIOSCIEROSIS DUE TO (OR AS A CONSEQUENCE OF): ACTERIOSCIEROSIS DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | many years | |
| N C | PART II. Other aignificant conditions | contributing to dec | eth but not resi | uiting In | the underlying | ceuse given ir | Part I. 2 | te. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | HYPERTENSION | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| Σ | DISTASE, CONVIEST DID TOBACCO USE CONTRI | | | | | | | | / | | 1 - YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | IOSPITAL: | | OF DEATN | (Check only one) | | | | | | |
| YSI | 1 YES 2 KNO | ☐ Inpetient 2 ☐ ER | /Outpatient 3 🗆 | | OTHER: Nursing Nom | e 5 🗆 Residenca | 6 Other (S | Specify) | | | |
| ву Рн | 27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJ (Month, Day, Y | | Bb. TIME | RY WO | | 26d. DESCR | IBE NOW I | URY OC | CURED | |
| | 3 Suicide 6 Could not be 4 Homicide detarmined | 28a. PLACE OF IN. building, etc. | JURY — Al home, (Specify) | , ferm, str | eet, tectory, office | | 281. LOCATI City or | ON (Street a lown, State) | nd Number | or Rural Ro | oute Number, |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CA CERTIFYING PHYSICIA 2 MEDICAL EXAMINER: | | | | | | | | | | and manner as stated, |
| TO BE (| 296. SIGNATURE AND TITLE OF CERTIFIER ROLLING ROLLING | a MD | | | | DQ75 | MBER 41 | | 29d. DATI | SIGNED (| Month, Day, Year) 19, 1996 |
| | Getha Ray 30. NAME AND ADDRESS OF PERSON WHO O | 4367 HO | PRESTO (ITEM 2 | Dary | Rd, | Baltin | reve i | ND. | -21 | 22- | 7 . |
| | 31. DATE FLEB 1. 3. 1996 | A PERSTANS | SIGN TUBE ALL | | | | | | | | T-T |



ITEM: 7. PER F.H. FILM G-752 ease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 2/13/96 t.t 3604 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Yeer 0228 Am awn 8 vebruary /Medical 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death 4b. City. Town, or Location of Deeth Examiner If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 105/1291 5. Social Security Number 6. Sex 159/ Cignor 7. Age (In yrs. lest birthdey) Funerai 29 215-82-4409 1 M 2 F Months Yrs. Director Usuel Residence of Decedent with the Maryland 10e. Stete County Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Experies must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director WINA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ENNINGTON CIRCLE UZA 2111 death Funeral 12. Wes Decedent Ever in U,S. 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Armed Forces?

1 Yes 2 No
If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. Important: If Item 27 is marked other then "natural", or ite, any injury or other treumatic event, the Medical Exerctions. 2 Merried 1 ☐ Never Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify: If Yes, Give Yeer or Detes: à 3 Widowed 4 Divorced Specify: ac Completed 16s. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) JANItorial 2+1 JANITORESS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Frandville 1 ma 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ANB. ELCER 40 acqueline 5310 Nelson Saltimore, 20a. Method of Disposition
1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, cremetery of other 20c. Location - City or Town, Stele lact emebre 2-13-96 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March 21215 4300 Wa 23a. Part. Enter the crosses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hour fairns. List only one cause on each line. Approximete Intervsi Between Onset and Death mmuno deficiency **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of). Examiner heu hed hice use es the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or es e consequence of): sttending physician for use es the buria Box 68760 0) 402 Physician/Medical Due to (or es e consequenca of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24s. Was an eutopsy performed? paga 2 s 2 0 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 D Inpatient 2 □ ER/Outpatient 3 □ DOA P 報 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. fnjury et Work? Affer 7 Certification: 28d. Describe how Injury occurred darfor Attender Court. A Director: A 1 Neturel 2 - Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. To the Host within 24 ho To the Funar completely III Medical 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 32/Registrar's Signeture

5 Julia Murchan Randall 31. Dete filed (Month, Dey, Year) 120htall stown State Registrar **DHMH 16 Rev 6/95**



| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTA CERTIFIC | | | MENTAL HYGIEN | Ε | | | | |
|---------------|---|--|--|-----------------|------------------|--|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | <u> </u> | AIL OI | DEATH | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | Hilda Somers | | | | | January 26 | | | | | |
| | | | and the same of th | UNDER 1 YEAR | IF UNDER 24 HRS. | 7 DATE OF BIRTH | 8. BI | RTHPLACE (State or Foreign | | | |
| | | | OO YRS. | NTHS DAYS | HOURS MIN. | | 1929 Br | yson City, N.C. | | | |
| ~ | 9a. FACILITY NAME (If not institution, give street | et and number) | 91 | | R LOCATION OF DE | EATH | 9c. COUNTY C | | | | |
| TO | 7616 Haines Court | | | Laur | el | | Prince George's | | | | |
| DIRECTOR | MD 106. COUNTY Prince | George's | 10c. CITY, T Laur | OWN OR LOCAT | ION | | 10d. INSIDE CITY LIMITS? 1 1 YES 2 NO | | | | |
| | 10e. STREET AND NUMBER | | | 101, ZIP CODE | | | 10g. CITIZEN (| OF WHAT COUNTRY? | | | |
| FUNERAL | 7616 Haines Court | | | | 20707 | | Unite | d States | | | |
| 5 | | 2. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | | | IIC ORIGIN? (Specify Yes | or No- 14. F | IACE - American Indian, Black, White, etc. | | | |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ATES | | 2 NO Specify | | | Specify: White | | | |
| ED | 15. DECEDENT'S EDUÇAT | TION | IN . | 16b. KIND OF BU | RINESS/INDUSTE | | | | | | |
| ETE | (Specify only highest grade co | mpleted) College (1-4 or 5+) | (Give kind of work life. Do NOT use re | st of working | 100 11110 01 00 | | " | | | | |
| COMPLET | 12 | 2 | Register | ed Nurs | se | Medical | | | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Meiden | Sumame) | | | | |
| W | Ellis S. McHan | | | | Parcie . | Johnson | | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Anita Somers | | ourt Lau | rel, Maryl | and 207 | 07 | | | | | |
| | 20e. METHOD OF DISPOSITION 137 Burial 2 Cremation 3 12 Remove 4 Donation 8 Other (Specify) | al from State | DATE 20c. LOCATION - City or Town, State 1/30 Bryson City, N.C. | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SEINIGE LICEN | |) Jeniet | | ID ADDRESS OF FA | | , 5011 011 | | | | |
| | COOCO | Desto | | | | Home Inc. | Laurel. | Maryland 2070 | | | |
| | 23. PART I. Enter the disease, or cor/shock, or heart fullure. Lis | mplications that cured | Ne desth. Do not | | | | | Approximats | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | Onset and Death | | | |
| | disease or condition resulting in death) | Metasta DUE TO (OR AS A | He Sm | all (| ell lus | 19 Car | 1cer | 144 | | | |
| | | DUE TO (OR AS A | CONSEQUENCE OF): | | | 1 | | | | | |
| NO | Sequentially list conditions, b. | | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| FIC | CAUSE (Disease or injury thet initieted events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| FE | reaulting in death) LAST | | | | | | | | | | |
| | DARRY II. Onto a classic control of | | | | | | | | | | |
| AL | PART II. Other aignificent conditions | contributing to death b | ut not resulting in t | the underlying | g ceuse given in | Part i. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| MEDIC | | | | | | 1 YES 2 | DINO | COMPLETION DF CAUSE DF DEATH? | | | |
| | DID TODA CCO LICE CONTROL | DUTE TO CALICE O | E DEATH VEC | | LINICEDTALI | | | 1 TES 2 NO | | | |
| A | DID TOBACCO USE CONTRI | | 26. PLACE OF DEATH | | UNCERTAIL | NE | | | | | |
| SICIAN: | EXAMINER? | HOSPITAL: | 0 | THER: | | 1 m 2011/2-01 v | | | | | |
| PHYS | 27. MANNER OF DEATH | 26a. DATE OF INJURY | 26b, TIME O | | | 8 Other (Specify) 28d. DESCRIBE HOW I | N.ILIBY OCCUBE | 0 | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJUR | y WC | RK7 (ES 2 NO | 200. 0200.102 11011 | HOOM OCCURE | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY | - At home, larm, stre | | | 281, LOCATION (Street | and Number or Ru | irel Route Number, | | | |
| TED | 4 Homicide determined | building, etc. (Spec | cify) | | | City or Town, State) | | | | | |
| ٦ | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| COMPLET | 2001 | | | | | | | rse(s) and manner as stated. | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 7 | | | 29c. LICENSE NUI | | | NED (Month, Day, Year) | | | |
| BE | Tankal M | Bon a | 16 | | 1227 | _ | 200 | 28-96 | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Pri | int) | par! | | | - 70 | | | |
| | 5454 Wisconsin Av | enue #1345, | Chevy C | hase, N | Maryland | 50015 | | | | | |
| | FEB 1 3 1996 Jul | 32 REGISTRAR'S SIGN | ATURE | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 96 03606

| | | | | | Certificate of | | | g, No. | 0 | 3000 |
|--|---|------------------------|--|---|---|---|---|-------------------------------|-------------|---|
| П | Physici | an | Decedant's Name (First, Middla, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death | | | |
| J | /Medi | | STANLEY | SCH | ERR | | FEBRUAR' | | | 8:55pm |
| b | Examir | ner | 4a. Facility Name (If not institution, give street and number) | | 4 | 4b. City, Town, or Lo | | 4c. County | of Death | |
| | | | 35 STONEHENGE CIRCLE, APT. 3 | | | BALTIMOR | | BALTI | | |
| | Funeral Director | | 5. Social Sacurity Number 218-36-9900 Usual Rasidence of Dacedant | yrs. last birtho | Months Dava | If Under 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day, JULY 17 | ,1912 | | lace (State or Foreign try) YLAND |
| | h the Maryland r 28a-f show | _ | 10a. State 10b. County 10c | . City, Town o | or Location | | | | 1 | Od. inside City Limits |
| | Ba-I | MARYLAND BALTIMORE BAL | | | | | | 1 ☐ Yas 2 📉 N | | |
| | or 2 | Dic | 10e. Street and Number | | 10f. Zip Coda | | 10 | 10g. Citizen of What Country? | | |
| | ath w | rai | 35 STONEHENGE CIRCLE, APT. 3 | | | 21208 | | USA | | |
| 21215-0020 | 72 hours after death with the Maryland naturel', or Nems 23s or 28s-f show dess Enaminer must be not be dat | by Funeral | 11. Marital Status 1 □ Nevar Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forcas? 1 ☒ Yas 2 □ No if Yas, Give Year or Datas: ₩ | if Yas, specify Cu 1 □ Yes 2X No | | lispanic Origin? (Span, Mexican, Puarto Specify: | ecify Yaa or No- Rican, atc.) | | k, Whita, | an Indian, atc. WHITE |
| 2-0 | 72 hours "natural", | Completed | 15. Decedant's Education | 16a. Decedant'a Usuei Occu (Giva kind of work dona | | ation | 1 | 6b. Kind of Bu | | |
| 21 | c | pje | (Specify only highast grada complated) Eiamantary/Secondary (0-12) Collega (1-4or 5+) | - (C | ina kind of work dona (fa. DO NOT usa retired | during most of worki d) | ng | | | |
| | | Con | 5+ | | ATTORNEY | | | LA | W | |
| pu | be filed tal Hygie d other event, u | Be (| 17. Father's Nema (First, Middla, Last) | | | 18. Mothar's Name | (First, Middla, M | aiden Sumam | e) | |
| Maryland | HERMAN SC. | | | | ERR | | ETTA | AM | OLSK | Y. |
| ar | and la ma | | 19a. Informant's Name/Raiationship (Type, Print) | 19b. N | leiling Addrass (Street | and Number or Rura | al Routa Number, | City or Town, | Stata, Zip | Code) |
| Baltimore, N | gas 1 and t of Health If Hem 27 or other tr | | MR. H. ROBERT SCHERR (SON) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from Stata | ROAD GLET | Data 2 | Oc. Location - | City or To | | | |
| 틒 | nit. Pa sartmen ortant: injury | | 4 Donation 5 Other (Specify) | ARL. | INGTON-CHIZ | | -2-9-1996 | BALTI | MORE | , MD |
| Ba | permit. P Departmo Importan any injur | | 21. Signature of Funaral Sarvice Licensea | | 22. Nama and Addra SOL LE 6010 REIST | EVINSON & | | | | 21215 Approximata |
| 68760, | Physician be executed g physician and as the burial-transit as the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Entar Underflying Cause (Diseesa or Injury that inflience are the cause. | to (or as a cor | nsequence of): | -Por | 057103 | PB | | Onset and Death 6 JRS 4 JRS |
| Box 6 | | Physician/Me | d | | | | | 17-0 | | |
| | a dee the et ned fo | sici | Part II. Other significant conditions contributing to death but not | rasulting in th | na undarlying causa giv | an in Part i. | 23b. Dld tob | acco une con | tributs to | the causs of death? |
| , P.O. | ires that the deeth cert signed by the ettendin d be detached for use | by Phy | ISONFONIC NT. |)/58 | NSE | | 1 🗆 Ysı | 2010 | 3 Prol | pably 4 Unknown |
| Records, | aw requ | Completed b | | | n - | | 24a. Waa an perform | autopsy ed? | avi | ere autopsy tindinga silable prior to mpletion of cause death? |
| | ysicient: Tha i is certificate ha director, page | 00 | | | | | 1 ☐ Yas | 2/1NO | 1 🗆 | Yas 2 No |
| Vita | certificate rector, pag | Be (| 25. Was case refarred to medical axaminar? | | | 26. Placa of Death | (Check only ona |) | | |
| | is ce dire | 2 | Hospitai: | 2 ER/Outpe | atient 3 DOA Oth | ar: 4 Nursing Ho | me 5 Residan | nce 6 Othe | er (Specify | 1) |
| 0 # 53 | | | | | | | | v injury occurre | ed | |
| | M Direct | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be datarmined 28e. Pleca of Injury - J building, atc. (Sp | At homa, farm ecify) | , streat, factory, office | 1 | 28f. Location (Stre City or Town, | eet and Numbe Steta) | er or Rura | l Route Number, |
| 29a. Cartifier (Check only one) 29a. Cartifier (Check only one) 29b. Signature and fittle of certifier 29c. Licanse number 29d. Data signed (More control of the course) | | | | | | | nnar as st ind dua to | etad. tha cause(a) | | |
| | To the within To the comple | Σ | 29b. Signature and fills of certifler | / | 29c. Licanso | | 29 29 c | d. Data signed | (Month, | Day, Year) |
| | | | 30. Nema and addrass of parson who completed cause of design | 10m 23a) (Ty | pe, Print) | ,0~ | | 1 1 | | |
| | Sta Registr | | TEB 1 3 1996 | PLANE. | : | | | | | |

Physicia /Medic Examin

Funeral Director

28a-f ehow

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baitimore, Maryland 21215-0020

| - ! | 510 | Plea | se Type or | Print in I | Black In | delibl | e Ink | c. Assi | ure A | Il Coples | Are | Lec | ible. | |
|--|--|--------------|----------------------|------------------------|--------------------------|---|--|--------------------------------|-------------------|--------------------------------|--------------------------------------|------------|--------------------------|--|
| | | | | of Marylar | nd / Dep | artmer | nt of | | and N | | | е | 96 | 03607 |
| in al | 1. Decedent's Ner RAND | | , Last) PHONSUS S | MOOT | | | | | | 2. Dete of De Month FEB. | | ay I : | Yeer 1996 | 3. Time of Death 3:10 am |
| 4a. Facility Neme (If not institution, give street and number) 4300 BLK ROGERS AVE. | | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | | ty of Deet | | |
| | 5. Sociel Security | Numbar | 6. Sex 1∕□ M 2□ F | 7. Age (In yrs. 33 | . last birthday) Yrs. | If Unde Months | | | r 24 Hrs. Min. | 8. Deta of Bi | rth 87 19 | 62 | 9. Birth | hplece (Steta or Foreign untry) MD |
| MD DAITTMODE OU | | | | | Ity, Town or Lo | | <u> </u> | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 🛱 No |
| Funeral Director | 10e. Street and No. | INGTON | | | | 10f. Zip Code 21111 | | | | | 10g. Citizan of Whet Country? U.S.A. | | | |
| þ | 11. Marital Status 1 Never Mar 3 Widowed | ried 2 Merri | Armed F | 2 X □ No ive | | S. 13. Wes Decedent of Hispanic Origin? (Specific Yas, specify Cuben, Mexican, Puerto F | | | | | D- | BI | ace - Amai ack, White | |
| | | | | | | dent's Usu kind of wo DO NOT u NKNOW | ork done ise retin | ipation i during mos ed) | st of work | sing | | KIND of | Business/I | industry |
| 17. Father's Nema (First, Middle, Last) EDWARD A. SMOOT | | | | | | | 1 | | e (First, Middle | , Meide | n Sume | ema) | | |
| 19e. Informent's Neme/Reletionship (Type, Print) EDWARD A. SMOOT (FATHER) 19b. Melling Address 716 CHAPE | | | | | | | | | | | n, Stete, Z 229 | (ip Code) | | |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Itema 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 2008s.

Physician /Medical Examiner

Physician/Medical Examiner ettending physician and for use as the buriel-tran been signed by the e Be Completed by After this certificate has funerel director, page 2 Aptial Or Attending Physician: The polys afterdeath.

Person Director: After this certificate yilled in by the funeral director, pa Certification: To

The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

22. Nema and Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD 21217 sed the deth. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximete Interval Between Onset and Deeth Immediate Ceuse (Finei disaase or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Dua to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the undariying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

2/6/1996

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

WOODLAWN CEM.

20c. Location - City or Town, Stata

BALTO. MD

2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Xes 2 No 2 No 25. Wes case referred to medical exeminer?
1 XYes 2 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) SCEN 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1-96 Doce de 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number City or Town, Stata)
4300 BILL, Logers AVL. 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical (Check-q)

29b. Signature and title of certifier 29c. License number

29d. Data signed (Month, Day, Year)

O.C.M.E. FEBRUARY 01, 1996

and eddress of person who completed cause of deeth (item 23a) (Type, Print)

J. Ut for 111 PENN STREET BALTIMORE, MARYLAND 21201

31. Data filed (Month, Dey, Year) State 3 1996 Registrar

32. Registrer's Signeture

To the within To the 1 N Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete

4 ☐ Donetion 5 ☐ Other (Specify)

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DHMH-16 Rev 1/89

Pages 1, 2, 3 should

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Item State certificate

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TO THE FUNERAL OIRECTOR: Af be filed within 72 hours after de IMPORTANT: If Item 28 Is 1

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Hygiene prior to

the attending p

has been signed by Dept. of Health and

and completely fi burial, cremation

and

physician

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| RECORDS, P.O. BOX 6876 | certificate |
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| OF VI | PHYSICIAN: |
| DIVISION OF VITAL I | PITAL OR ATTENDING F |
| 7 | 8 |
| _ | PITAL |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH repruary 5,1996 YEAR 6:58 P Clarence Spence 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7-3-25 218-16-1131 70 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH Maryland General Hospital Baltimore City Baltimore City DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY BALTO. CITY BALTIMORE 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 717 DRUID PARK LAKE DRIVE APT. 402 21217 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify BLACK 1 TES 2 NO Specify: BY 3 Wildowed 4 Divorced ED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high H Elementery/Secondary (0-12) COMPL UNKNOWN UNKNOWN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) ELIJAH SPENCE ADDIE SPENCE 19e. INFORMANT'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY HOLLAND SEQUOIA AVENUE BALTIMORE, MARYLAND 21215 20a, METHOD OF DISPOSITION
1 Aburlet 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State GARRISON FOREST CEM. 2/9/1996 OWINGS MILLS MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ESTEP BROTHERS FUNERAL HOME P.A. ESTEP BROTHERS FUNERAL HOME P.
1300 EUTAW PLACE BALTIMORE MD

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart feiture. List only one cause on each line. 1300 EUTAW PLACE BALTIMORE MD 21217 interval Between **Onset and Death** IMMEDIATE CAUSE (Finel disease or condition Lung Cancer resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF) Emphysema CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in death) LAST PART il. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2XNO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 TES 2 NO 1/1 Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural
2 Accident 1 YES 2 NO BY 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide 29a. CERTIFIER
(Check only one)
20

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated.

MEDICAL EXAMINED: On the best of examination and/or important and the time, date end place, and due to the cause(e) end menner as stated. COMPL 2 MEDICAL EXAMINER: On the baste of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(a) end menner se stated. 29h, SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) milsuaya 39263 5 96 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Elisaveta Melshaya, M.D. c/o Maryland General Hospital 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

FEB 1 3 1996

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 6 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death SCOTT FEISRUARY 9 96. STERLING 0200 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSP I TAL CONTER RANDALLSTOWN NORTHWEST BALTIMORE | Hundar 1 Yaar | Hundar 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | 06/24/1961 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 18 M 2□ F MARYLAND 220-76-8185 Usual Rasidance of Dacedant 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BALTIMORE BALTIMORE 1 Yas 2 No 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6641 DALTON DRIVE 21207 U.S.A. 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Marriad 2 Married Specify: BLACK 1 ☐ Yas 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) **GLASS OPERATOR** CARLO GLASS CO. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) JOHN T. SCOTT BETTY HICKS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) BETTY COLE (MOTHER) 6641 DALTON DRIVE BALTIMORE, MARYLAND 21207 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) WOODLAWN CEMETERY 2/14/1996 WOODLAWN, MARYLAND 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME PA. 23a. Part 1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Interval Between Onset and Death 46 Immediate Cause (Final disaasa or condition rasulting In death) Due to (or as a consequenca of): Dua to (or as a consequance of): Dua to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? KAPOSI'S SARCOMA 1 ☐ Yee 2 ☐ No 3 ☐ Probebly 4 ☑ Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

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physician the burlai

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certificate

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death.

or Attend after death Director: /

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Certification:

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Physician

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item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or itema 23s any injury or other traumatic avant

Maryland 21215-0020

Baltimore,

Box 68760

Division of Vital Records, P.O.

the Maryland

Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaase or injury that initiated evants rasulting in death) Last Physiclan/Medical Completed

1 ☐ Yas 2 ☐ tNo 26. Placa of Death (Check only one)

1 ☐ Yes 2 ₺ No

25. Was casa rafarred to medical axaminar? 1 Yas 30 No

28a. Data of Injury (Month, Day Year) 5 Panding Invastigation

30. Name and addrass of person who completed cause of death (Itam 23g) (Type, Print)

28b. Tima of

Hospital: 1 Pinpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Yas 2 No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office bullding, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one)

27. Manner of Death

1. Natural

2 Accidant

4 Homicida

3 Sulcida

1 🖟 Certifying Physician: To tha best of my knowledge, daath occurred at the time, date and place, and dua to tha causa(s) and mennar es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certiflat

6 Could not be datarmined

29c. Licensa number

29d. Data signed (Month, Day, Year) REBRUARY 9

· RAVIMD 31. Data filad (Month, Day, Year)

BALTO 32. Registrar's Signature

Registrar

State

Jalin Benderhard

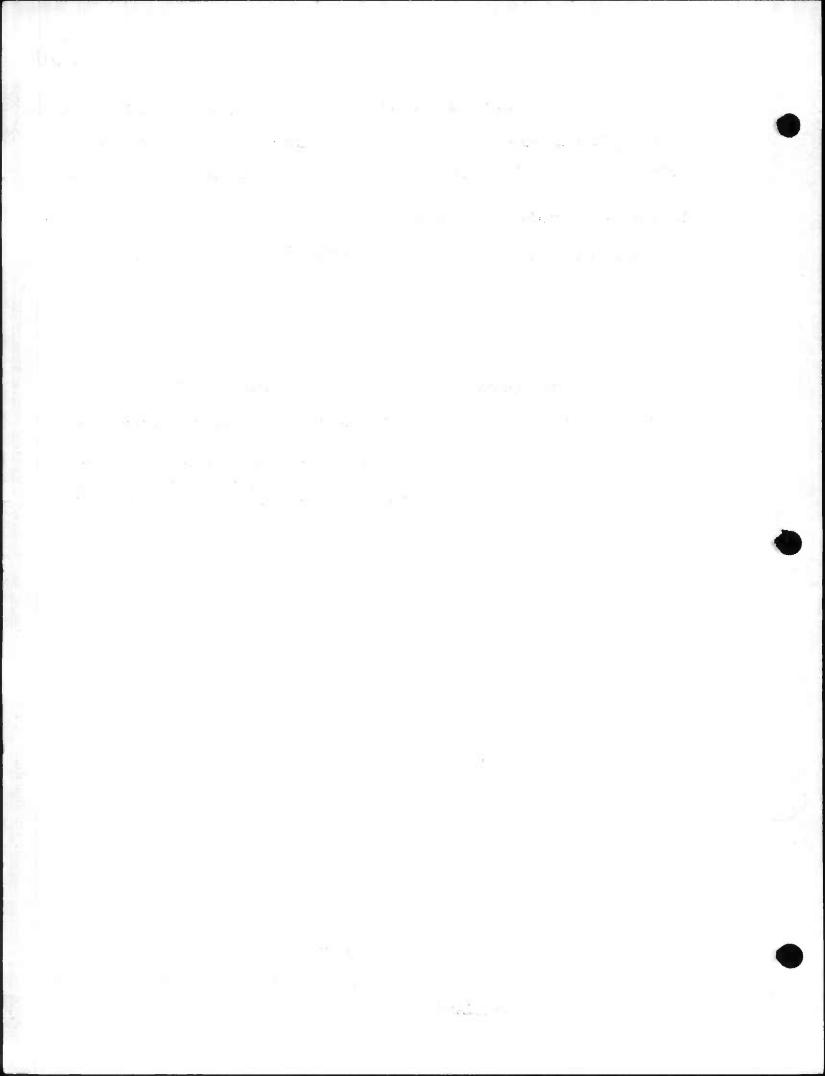
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 6 0 3 6 1 0

| | | | | | , | Cei | rtificate of | f Death | | Reg. No. | U | 3010 | |
|------------------------|--|----------------------------|--|--|-------------------------------------|---|--|---|---|------------------------------------|------------------------------|---|--|
| | Physic | an | Decedent'a Name (First, Middla, La | | | | | | 2. Data of Dea | ath Day | Yaar | 3. Tima of Death | |
| J. | /Medi | | | | Earli | ne | Stern | | Februa | ry 12 | 1996 | 1:30 A.M | |
| H | Exami | ner | | | | | | | | | | 3 - 3 | |
| Н | Funeral | | | | (in yrs. last l | birthdey) | If Undar 1 Yea | | | | ne Arı | | |
| Ü. | Director | , | | 1□M 2점F | 54 | Yrs. | Months Day | s Houra M | in. 8. Dete of Birt (Month, Da) May 4, | 1941 | Mary | aca (Stata or Foreign try) /land | |
| | yland | | 10e. Stete 10b. County | | 10c. City, To | wn or Lo | cation | _ | | | 10 | Od. Insida City Limits | |
| | Mar Dred | ctor | Maryland Anne Ar | rundel | Pasa | idena | ı | | | | | 1 ☐ Yas 2 No | |
| | th with th | Funeral Director | 10e. Street and Number 7875 Elizabeth 1 | Road | | | 10f. Zip Code 211 | | | 10g. Citizan of What Country? U.S. | | | |
| 21215-0020 | be filed within 72 hours after death with the Maryland hal Hyglene. d other than "natural", or items 23a or 28a-f show svent, the Modical Exerting must be nooted. | by | 11. Meritei Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Dacedant E Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yeer or Detas: | | | Was Decedant of f Yas, specify Cu 1 ☐ Yas 2 ☑ No | | (Specify Yes or No- erto Rican, atc.) | 14. Rac Bla Specifi | ca - America ck, White, e | | |
| 5-0 | 72 ho | Completed | 15. Decedant's E (Specify only highest gr | | 16 | Sa. Deced | iant's Usuel Occi | upation a <i>during</i> most of w | vorkina | 16b. Kind of Businass/Industry | | | |
| 121 | within ene. | mpk | Elamentary/Secondary (0-12) | Collega (1-4or 5- | +) | | | a during most of w | Retail Sto | | | | |
| d 2 | Hygie ther ther | | 12th 17. Fathar's Nama (First, Middla, Last |) | | Cle | :LK | 18. Mother's N | lama (First, Middla. | | | е | |
| lan | should be filed valued by the state of the s | To Be | I | Earl Beahm | | | | | lama <i>(First, Middl</i> a, <i>Meidan Sumam</i> a) Viola Knight | | | | |
| Maryland | s 1 and 2 should I Health and Mer Itam 27 Is marke other traumatic | - | 19a. Informant's Name/Relationship (| Type, Print) | 19 | 9b. Mallin | ng Addrass (Stree | et and Number or | Rural Route Numbe | r, City or Town, | Stata, Zip | Code) | |
| | Health am 27 learn tra | | William L. Stern | n | | | Elizabe | | Pasader | na, Mary | land | 21122 | |
| Baltimore, | Pages 1 a nant of Hea int: If Itam | | 20a. Mathod of Disposition 1 ☐ Burial 2 【ACramation 3 ☐ 4 ☐ Donetlon 5 ☐ Othar (Specil | | | sition (Nama of natory or other pi ematory, | | Data 2/14/96 | 20c. Location - | - X | m, Stata Maryland | | |
| Balt | permit. Pages Department of Important: If it any Injury or o | | 21. Signature of Funeral Service Licer | 1500 | hi | | Nama end Add | | Gonce F way Balt | | | | |
| | Physician /Medical Examiner | | 23a. Part 1. Enter the disease or some shock, or heart failure. Life only immediate Cause (Final disease or condition resulting in death) | a Core | | 4/ | Artery | ving, such es card | | rast, |) | Approximata Intarval Batween Onset and Death | |
| lox 68760, | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Medical Examiner | Sequantially list conditions, if ery, leading to immediate cause. Entar Undarfying Cause (Disease or injury that infliated avents resulting in death) Last | b. Dia | betes Dua to (or as a | a conseq | tellit | us_ | | | | ONE WONT | |
| O. E. | a deat | sici | Part ii. Other significant conditions of | ontributing to death bu | t not resulting | in the un | ndarlying causa g | iven in Pert I. | 23b. Did t | obacco use co | ntribute to | the cause of death? | |
| s, P.O | v requires that tha death cer been signed by the attendir should be detached for use | by Phy | | | | | | | 10 | res 2 No | 3 Prob | ebly 4 Unknown | |
| Ital Records, P.O. Box | law require las been sig | 9 | | | | | | | 24e. Was perfo | an autopsy med? | eva | re autopsy findings ilable prior to apiation of cause leath? | |
| <u> </u> | cate h | Co | | | | | | | 1 D Y | as 2 No | 10 | Yas 2 No | |
| ij | certific | Be | 25. Was casa rafarred to medical axaminar? | Hospitel: | | | 10 | ther | eath (Check only o | | | | |
| 5 | ng Phy fler this uneral di | on: To | 1 ☐ Yas 2 ☑ No 27. Manner of Death 1 ☑ Netural 5 ☐ Panding | 28a. Date of injung (Month, Day | Year) 28b | . Time of | 28c. inj | ury at ork? | Homa 5 Rasid | | |) | |
| Sic | tandl Jeath tor: A | cat | 2 Accident investigation 3 □ Suicida 6 □ Could not b | 0 00 0 | | NA | | Yas 2□No | NA | 4 | | | |
| Division | To the Hospital or Attanding Principant: The law re within 24 hours after death. To the Funeral Director: After this certificate has been completely illied in by the funeral director, page 2 should be the completely illied in by the funeral director, page 2 should be seen as a second | Certification: | 4 Homicide datarmined | building, atc. | (Specify) | | <u> </u> | | 281. Location (S City or Tow | n, Steta) | | | |
| | ne Hosp n 24 hou ne Funer pletely lii | edicai | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best of ninar: On the bests of and mennar stat | my knowlado axamination a ed. | ga, daath ind/or inv | occurred et the rastigation, in my | tima, data and pia opinion, daath oc | ca, and dua to the c curred at tha tima, o | cause(s) and ma data and place, | annar as ste and dua to | ated. the causa(s) | |
| | Withi To th Comp | ž | 250. Data signed in | | | | | | | | | | |
| | | | pans a | CUSEY | MD | | DE | 39411 | | 2/1 | 2/96 | , | |
| | 17 | | 30. Nama and address of person who | | |) (Type, I | Print) | 0 / | slen B | | N. 1 | 010/1 | |
| | \ () | | | | 406 | Cr | AIN thu | 4. S. E | zien B | urnu | , Md | . 2106 | |
| | Sta Registr | te ar | 31. Data filed (Month, Dey, Year) FEB 1 3 1996 | 32. Registra | Signatura | | | • | | | | | |



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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL | HYGIENE REG. NO. | | | | |
|--|--|---|---|-----------------------------|----------------------|------------------|--------------------------|----------------------|------------|----------------------|----------------------|
| 1 | 1. DECEDENT'S NAME (First Middle Leat) | ARCHER | SHEEH | | DEATH. | 2. DATE OF MONTH | | | EAR | TIME OF DE | |
| | 4. SOCIAL SECURITY NUMBER 5 | 5. SEX 8. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | FEB | | 199 | | CE (State or | |
| | 218-40-0102 | 1 □ M 2∑ F | 54 yrs. | MONTHS DAYS | HOURS MIN. | | Day, Year) | | Country) | | roreign |
| OR | 90. FACILITY NAME (If not institution, give stree SAINT JOSEPH M | EDICAL CE | NTER | "TOWSO! | N, MARY | LAND | | 9c.BAT | MTT | PRE | |
| | RESIDENCE OF DECEDENT | | | | | | | | _ | | |
| DIRECT | Maryland N/A | | | y, town on Locat ltimore | ION | | | | | I. INSIDE CI | |
| | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT CO | | | | | | | | | XYES 2 [| |
| FUNEHAL | 6003 North Charles | Street | | | 21212 | | | | S.A. | | |
| 2 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No. 14. RACE - An | | | | | | | | | American In | idlen, |
| 3 Widowed 4 Divorced IF YES, GIVE WAR OR OATES 1 YES 2 NO Specify: Specify: | | | | | | | | | | | |
| | i i wn | | | | | | | | | | |
| L L | (Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use retired.] [Give kind of work done during most of working life. Do NOT use retired.] | | | | | | | | | | |
| COMPLETED | 12 years Homemaker Own Home | | | | | | | | | | |
| _ | 17. FATHER'S NAME (First, Middle, Lest) Carvil Reid Archer 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Barbara Kunkel | | | | | | | | | | |
| ם | Carvii Reid Archer Helen Barbara Kunkel 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 0 | Peter Carroll Sheehan 6003 North Charles Street, Baltimore, MD 21 | | | | | | | | | | |
| | 20a METHOD OF DISPOSITION 1 M Burial 2 Cremation 3 Remova 4 Donation 5 A Other (Specify) | al from State | b. PLACE AND DATE OF THE CONTROL OF | | | 2/14 | | ation – cit chvil | | | and |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | 7 | | ND ADDRESS OF FA | | | | 10, 1 | HIL y A. | and |
| | 1 hours 10 | such Dero | X | | ell-Wied York Rd. | | | | 1212 | | |
| | 23. PART I. Enter the diseases, of cor shock, or heart fellure. Lis | | | | | | | | | Approxi | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | Onset a | Between and Death |
| | disease or condition resulting in desth) e. | ASPIRATI | | | | | | | | 10 | DAYS |
| | | DYSPHAGI | A CONSEQUENCE OF | | 0 | | | | | 5 D | AYS |
| O | Sequentially list conditions, if any, leading to immediate | | A CONSEQUENCE OF | | 0 | ~ | | | | - | |
| HTIFICATION | csuse. Enter UNDERLYING CAUSE (Disease or injury | MULTIPLE | | | | | | | | 20 | YRS. |
| | that initiated events resulting in deeth) LAST | DUE TO (OR AS | A CONSEQUENCE OF | F): | | | | | | | |
| 5 | d. | | | | | | | | | | |
| AL AL | PART II. Other significent conditions | contributing to death it | but not resulting | In the underlying | g ceuse given in | Part I. 2 | 24a. WAS AN A PERFORM | | AW | RE AUTOPSY | OF TO |
| | | | | | | — · | 1 TYES 2 | XNO | OF | MPLETION O DEATH? | |
| Σ | DID TOBACCO USE CONTRII | RUITE TO CAUSE (| DE DEATH YE | S I NO I | UNCERTAIL | | | | 1[| YES 2 | NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEA | |) Olyceniza | 14 12 1 | | | | | |
| PHYSICIAN: | EXAMINER? 1 VES 2 NO 1 | HOSPITAL: 1 Competient 2 ER/Out | tpetient 3 DOA | OTHER: 4 Nursing Hom | ne 5 🗆 Residence | 8 Other (| (Specify) | | | | |
| PHY | 27. MANNER OF DEATN | 26a. OATE OF INJURY (Month, Day, Year) | 26b. TIM | E OF 28c. INJ | | _ | RIBE HOW IN | JURY OCCU | RED | | |
| T S Netural 5 Pending M 1 YES 2 NO | | | | | | | | | | | |
| 288. PLACE OF INJURY - At home form street factory office 281 LOCATION (Creek and Number of Build David Number | | | | | | | | | | | |
| 4 Homicide Medical M | | | | | | | | | | | |
| one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | | | | | | | | | | n stated. | |
| מני | 29b. SIGNATURE AND TITLE OF CERTIFIED | 1 - 110 | | \cap | 29c. LICENSE NUI | MBER | | 29d. DATE S | GIGNED (Mo | onth, Day, Ye | or) |
| 2 | <u> </u> | walls | , m | V_ | D 258 | 886 | | ► 2. | 11 | . 96 | - |
| - | 30. NAME AND ADDRESS OF PERSON WHO | | 1 11713 | | , TOWS | ON. M | MD 21 | 204 | | | |
| 1 | 31. DATE FILEO (Month, Day, Year) | REGISTRAR'S SIGN | NATURE | JIM M. | 7 101100 | OII / I | 10 21 | 201 | | | |
| | FEB 1 3 1996 | N STRUMBURE THE | la M | | | | | | | | |

Sr. c. b

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Improcramt: If flem 27 is marked other than "natural", or frems 28a or 28a-f show any injury or other treumetic event, the Magical Esantmer mass has natural.

Physician /Medical

Examiner

physician end s the bunai-transit

datach

hes

To the Hospital or Attending Physicities 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directorials.

ital Records, P.O. Box 68760.

Division of

Examiner

Physician/Medicai

þ

Completed

Be

Certification:

Medicai

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

0745AM

| | | 1. Decedent's Name (First, Midd | fle, Last) | | | | | | 2. Date of Death |
|---|-----------------------|--|----------------------------|---|-------------|--------------|--|----------------|------------------------------------|
| | Physician /Medical | WILLIAM | Α. | STOCE | STOCKUM JR. | | | • | |
|) | Examiner | 4a. Facility Neme (If not institution 1600 FLEET S | | um <i>ber)</i> | | | | | ocation of Death |
| | Funeral Director | 5. Sociel Security Number 212–24–3990 | 6. Sex X XM 2□ F | 7. Age (In yrs. lest birthdey) 64 Yrs. | | Year Deys | | 4 Hrs. Min. | 8. Date of Birth (Month, Dey, Y |

4c. County of Death N/A Birthplece (State or Foreign Country)

1931

Usuei Residence of Decedent 10a. Stete 10b. County Maryland

Director

Funeral

þ

Completed

10c. City, Town or Location Baltimore City

10d. Inside City Limits NOXYas 2 □ No

Maryland

10e. Street and Number

621 South Bethel Street

21231 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) U.S.A. 14. Race - American Indian, Bieck, White, etc.

1 Never Merried 2 Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S.
Armed Forces?
1 [XYes 2] No
If Yes, Give
Year or DatesKorean War

1□Yes ANNo

10f. Zip Code

Specify: White

10g. Citizen of What Country?

1996

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Coilege (1-4or 5+) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver

16b. Kind of Business/Industry Furniture

17. Father's Name (First, Middle, Last)

William Alexander Stockum

City

18. Mother's Neme (First, Middle, Maiden Sumeme) Miriam Elizabeth Cassatt

19e. informant's Neme/Reletionship (Type, Print)

19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 621 South Bethel Street Baltimore, MD 21231

9/12/96

June Stockum 20e. Method of Disposition

1 ☐ Buriel ★ Cremation 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) Green Mount Cemetery Dete 20c. Location - City or Town, State

21. Signeture gunerel Service Licensee

22. Neme end Address of Facility
Lilly & Zeiler, Inc. Funeral Homes 2 1901 Eastern Avenue Baltimore, MD 21231

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Intervel Between Onset end Deeth

Baltimore, Maryland

Immediete Cause (Finel disease or condition resulting in death)

e. Upper Gastro-Intestinal Hemorrhage
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest

Due to (or as a consequence of)

Due to (or as e consequence of)

Pert Ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

Chronic alcoholism

24a. Wes en autopsy performed? partial

24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical XXYes 2 No

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work?

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence Nother (Specify) ON STREET 28d. Describe how injury occurred

27. Manner of Deeth Neturel 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E auste re

29d. Date signed (Month, Day, Year) FEBRUARY 9, 1996

Dennis J. Chutemo 31. Date filed (Month, Dey, Year) State

111 Penn Street, Baltimore, Maryland 21201

FEB 1 3 1996

32. Registrer's Signature

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

TO THE HOSPING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL UPLECOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

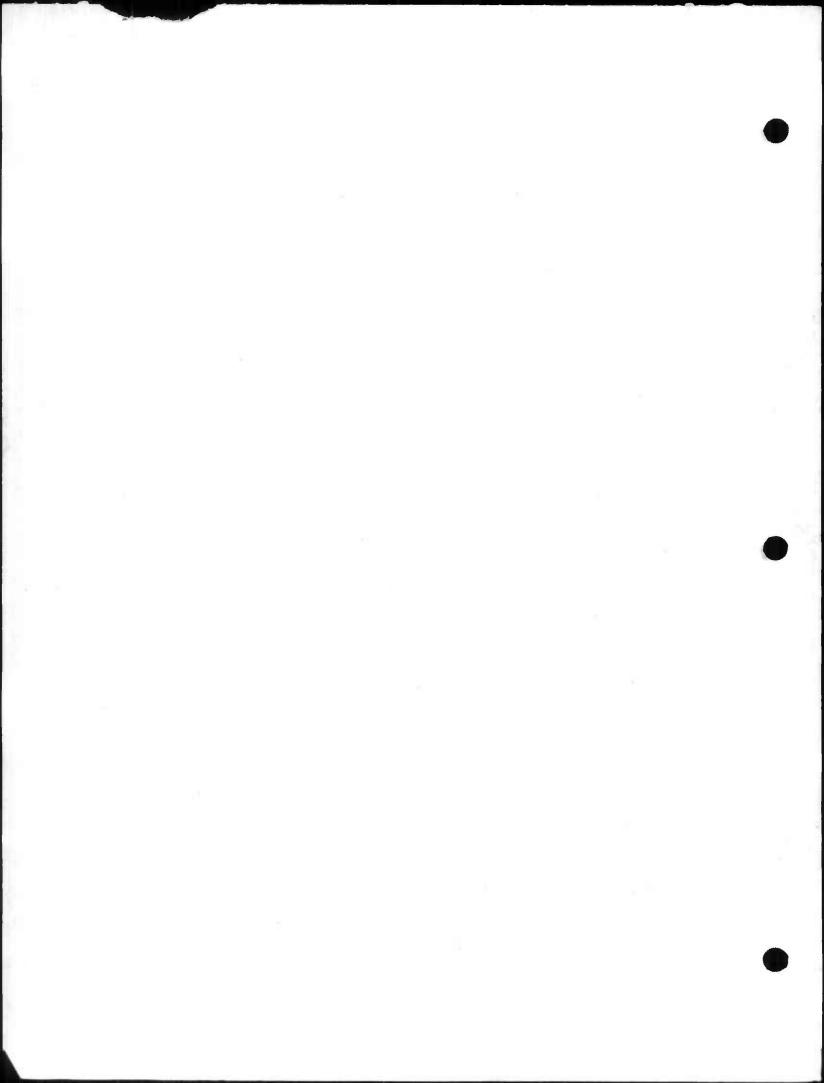
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DWISION OF VITAL RECORDS, P.O. BOX 68760

| 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
|--|---|---------------------------|----------------------------------|--------------|------------------------|-------------|---------------------------|-------------|--|------------|-------------|---|
| ? | 1. DECEDENT'S NAME (First, Middle, Last) | €. | SHAPI | Lo | | | | | 2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DEATH DATE OF DAT | | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | S. SEX | 8. AGE (In yrs. lest | | IF UNDER | 1 YEAR | IF UNDER 24 | HRS, | 7. DATE OF BIRTH | | 8. BIRTH | IPLACE (State or Foreign |
| | 370-01-0317 | 1 □ M 2X(X)F | 90 | YRS. | MONTHS | DAYS | | | | | Bal | timore, MD |
| ~ | Se. FACILITY NAME (If not institution, give street | | | | | | R LOCATION | | тн | | NTY OF D | |
| DIRECTOR | Holy Cross Hospita | al | | | 5: | TTAG | r Spr | ing | | MO | ntgo | mery |
| Di I | 18a. STATE 10b. COUNTY | | | 10c. CITY | , TOWN C | R LOCAT | ION | | | | | 10d, INSIDE CITY |
| E | Maryland Mont | gomery | | S: | ilve: | c Sp | ring | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | 84) | | | | | ZIP CODE | | | 10a, CIT | IZEN OF V | WHAT COUNTRY? |
| 3 | 901 Arcola Avenue | | | | | | 20902 | | | | U.S. | Α. |
| FUNERAL | | | EVER IN U.S. ARM | IED | 13. | MAS DECI | ENOENT OF | HISPANIC | C ORIGIN? (Specify Yes | or No- | 14. RACI | E — American Indian, |
| | | | | | | | | | k, White, etc. | | | |
| 6 3 W Wildowed 4 Divorced White | | | | | | | | | | | | |
| | 15. DECEDENT'S EOUCA' (Specify only highest grade co | TION Impleted) | 16a. DEC | EDENT'S | USUAL O | CCUPATIO | N st of working | | 16b, KIND OF BUS | INESS/INI | DUSTRY | |
| | | College (1-4 or 5+ |) Ho. | Do NOT us | e retired.) | , and | , or morning | | D -1 | T A | 1 | Coode |
| 15. DECEDENT'S EQUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs 17. FATHER'S NAME (First, Middle, Last) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of dwork done during most of working life. Do NOT use retired.) Sales Lady 16b. KIND OF BUSINESS/INDUSTRY Becker Leather Goods | | | | | | | | | | Goods | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | E (First, Middle, Maiden : | Surname) | | |
| BE | Louis Feinberg | | | | | | | | (Unknown) | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | ute Number, City or Town | | | |
| | Stanley D. Zimmer | man | | | | | | | rmantown, | | | |
| | 20s. METHOD OF DISPOSITION 1 ★ Burlal 2 □ Cremation 3 □ Remove | el from State | 20b. PLACE A cemetery, cren | ND DATE C | F DISPOS her place) | ITION (Na | me of 2/0 | 09/1 | 996TE 20c. LO | CATION — | City or To | own, State |
| | 4 Donation 5 Other (Specify) | VIOLE . | Mount | Leba | non | Ceme | etery | | Ade | Lphi | i, Ma | ryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENTIAL C. | Dist | theme | 45 | 23 UA | 2 CA | TREBRI ARROLI ICTON | L ST | REET, N.W. | DNERA | AL HO | DME, INC. |
| | 23. PART i. Enter the disesses, or co- shock, or heart fallure. Li | mplications that | caused the | sth. Do n | ot enter | the mo | de of dyln | g, such | as cardiac or respi | retory ar | reat, | Approximata |
| | ahock, or heart fallure. Lli iMMEDIATE CAUSE (Final | at only ona cau | sa on aach fina. | | | | | | | | | Interval Between Onset and Death |
| | | BILAT | KRAL | PN | LUM | | A- | | | | | DATE |
| ı | resulting in death) | DUE TO | OR AS A CONSEO | UENCE OF |): | | | | | | | 0,43 |
| z | C b. | | | | | | | | | | | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSEO | UENCE OF |): | | | | | | | |
| 2 | CAUSE (Disease or injury | | | | | | | | | | | |
| | that initiated events resulting in death) LAST | DOE 10 | (OR AS A CONSEO | UENCE OF | .): | | | | | | | i |
| 览 | d. | - | | | | | | | | | | |
| AL (| PART II. Other eignificant conditions | | | _ | | | | ven in P | art i. 24a. WAS AN | | 24b | . WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| | ULOSEPSIS; C | ANGERT | or HB | NRT | FAI | 1 | LE: | | 1 TYES 2 | | | COMPLETION OF CAUSE |
| MEDIC | ALZHEIMER'S | | | | | | , | | | ~ | | OF DEATH? |
| 2 | DID TOBACCO USE CONTRI | | | | | | UNCE | RTAIN | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACI | OF DEAT | | | | | | | | |
|)S | | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER 4 - Nun | | e 5 🗆 Resi | Idence 6 | Other (Specify) | | | |
| £ | 27. MANNER OF DEATH | 26a. DATE OF (Month, D | INJURY ay, Year) | 26b. TIM | E OF URY | 28c. INJ | URY AT | | 26d. DESCRIBE HOW II | NJURY OC | CURED | |
| BY | 1 Accident 5 Pending Investigation | | | | М | 1 🗆 1 | rES 2 | NO | | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE O building, | F INJURY — At hor etc. (Specify) | ne, ferm, s | treel, fact | ory, office | | | 26f. LOCATION (Street a City or Town, Stete) | nd Numbe | or or Rural | Route Number, |
| | 4 Homicide delermined | | | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSICI | AN: To the best of | my knowledge, des | th occum | d at the t | lme, data | and place, | and due to | o the cause(a) and men | ner aa sta | nted. | |
| S S | one) 2 MEDICAL EXAMINER: | On the basis of a | cemination and/or is | rveatigatio | n, in my o | pinion, d | eath occure | d at the ti | ime, data and place, an | d due to t | he cause(| a) and manner as stated. |
| | 296. BIGHATURE AND TITLE OF CERTIFIER | 1 | | | | | 29c LICEN | _ | | 29d. DA1 | TE SIGNED | (Month, Day, Year) |
| 3 BE | Neutra 2 Den | ul | | | | | D | 08 | 944 | • | 21 | 7 (96 |
| ٩ | MARTIN C. ST | OMPLETED CAUS | SE OF DEATH (ITEM | 1 27) (Type, | Print) | | 3720 | | TON M | מא | (| |
| | 31. DATE FILED (Month, Day, Ybar) FEB 1 3 1996 | | R'S SIGNATURE | | | | , (| | | | 37.1 | 'J. |
| | | | | | | | | | | | | |

a version of the first

| BALTIMORE, MARYLAND 21215-0020 | ter death. Page 6 may be retained by the hospital or attending physician. | continuous has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should to the Share Der. of Health and Mental Hygiene prior to burial, cremation, or removal. | al examiner must be notified at once. | COMPANY ON COLUMN OF THE CASE OF CE |
|---|--|---|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSE TRANSPORTED FOR SOLAR THE PROPERTY OF THE PROPERTY OF THE HOSE TRANSPORTED FOR SOLAR | TO THE FOREIGH DESCRIP. After this confliction has been signed by the attending physician and completely filled in by the fur- be filed within recently the commitment of the common of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT. Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | OF COMPLETED BY BUXGIOIAN. MEDICAL OFFICIONAL |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | | GIENE G. NO. | | MODERU . | | |
|--|--|--|---|-----------------------|---|----------------------------------|------------------------------|------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | | | | | YEAR 3. | TIME OF DEATH | | |
| | Jabria | Taylo | | | | 1 | 26 | 6 | 1448 pm | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIR (Month, Day,) | | B. BIRTHPL Country) | ACE (State or Foreign | | |
| | 9a. FACILITY NAME (If not institution, give stre | | | CITY, TOWN C | R LOCATION OF DE | Dec 12, | 1995 9c. COUNT | TY OF DEAT | Md | | |
| S | Franklin Sauce | e- Hospital | | Essex | | | | | County | | |
| [[| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c CITY TO | OWN OR LOCAT | ION | | | _ | d. INSIDE CITY | | |
| DIRECTOR | Md | NA | 2 | more | | | | | LIMITS? | | |
| | 10e. STREET AND NUMBER | Λ Λ | | | ZIP CODE | | 10g. CITIZ | | AT COUNTRY? | | |
| FUNERAL | 2204 Westfie | 1d Avenu | e | | 2121 | 4 | u | SA | | | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER I FORCES? 1 YES | 2 NO | If yes, sp | ENDENT OF HISPAR ecify Cuban, Mexica | n, Puerto Rican, e | | Black, V | - American Indian, Vhite, etc. | | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | MIES | 1 🗆 YES | 2 NO Specifi | y: | | Specify: | Black | | |
| COMPLETED | 15. DECEDENT'S EDUC. (Specify only highest grade of | (TION ompleted) | 18e. OECEOENT'S USI (Give kind of work | done during mo | ON st of working | 16b. KIND | OF BUSINESS/INOU | STRY | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | N/e. Do NOT use re | area.) | | 10.0 | | | | | |
| ₩ 0 | 17. FATHER'S NAME (First, Middle, Lost) | , | LAUR | | 18. MOTHER'S NA | ME (First, Middle, I | Melden Sumeme) | | | | |
| BEC | William Christian Jarrae autor | | | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street a | nd Number or Rural | Route Number, City | of Town, State, Zip (| Λ | | | |
| | 200, METHOD OF DISPOSITION | | b. PLACE AND DATE OF D | U L | ottield | PATE 2 | Da 141 1 | Hty or Town | 61214 | | |
| | 1 C Burlet 2 Cremetion 3 Remo | | metery: crematory of other | placel / | DZ. | 113146 | V | Stow | 1 | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | INSEE | | 22. NAME AF | D ADDRESS OF FA | CILITY | | | 21215 | | |
| | Xala / | Narch | | Mare | 4300 | Walte | sh Aven | up K | Bo Ho Hel | | |
| | 23. PART I. Enter the diseesea, or co shock, or heert failure. L | | | enter the mo | de of dying, suc | h as cerdiac or | reapiratory arre | est, | Approximate Interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | Onset and Death | | |
| | resulting in death) | Overwhelmin | ng Sepsis | | | | | | 6 Days | | |
| z | | Extreme Pre | | | | | | | 6 Weeks | | |
| 5 | if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | U WEEKS | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | OUE TO (OR AS | A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | |
| | PART II. Other algnificent conditions | contributing to death | but not resulting in t | he underlyin | a cause aiven in | Part I. 24e. V | WAS AN AUTOPSY | 24b. W | ERE AUTOPSY FINDINGS | | |
| N S | Congential Herpes | | | | | F | ERFORMED? | A | MILABLE PRIOR TO DMPLETION OF CAUSE | | |
| MEDIC | Anasarca, Infect: | | | _ | | X | YES 2 NO | | F DEATH? X YES 2 \(\subseteq NO | | |
| ž | DID TOBACCO USE CONTR | IBUTE TO CAUSE O | | | UNCERTAI | N 🗆 | | | | | |
| CI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH (| Check only one) THER: | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF INJURY | patient 3 DOA 4 | | URY AT | | HOW INJURY OCC | URED | | | |
| ВУ Р | 1 X Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUR | M 1 🗆 | PRK? | | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJUR building, etc. (Spe | Y — At home, ferm, etre | et, factory, offic | • | 281. LOCATION | (Street and Number of State) | or Rural Rou | ite Number, | | |
| Substitute City or Town, State) 29e. CERTIFFIER (Check only one) Check only one) City or Town, State) Certiffying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) and manner as stated. | | | | | | | | | | | |
| CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. | | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 1 | Triny Opinion, C | 29c. LICENSE NU | | | | fonth, Day, Year) | | |
| BE | Milyon | Elliot | 116 | | 7425 | 221 | > / | -21 | 2 - 9/- | | |
| ۵ | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF D | | | 1 | 2 0 | 1 | 3 | | | |
| | Melinda Ji | 1101115 | FSHC | 70C | OFran | Klin Sq | . Drive | Ba | Itimore, 41 | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | | | | U | | | | | |
| | FEB1 31996 | LOW WHITE | 16.14 | | | | | | DHMH-16 Rev 1/89 | | |



FOR

REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH FEBRUARY " 1996 RACHEL THOMPSON 12:40 рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH s. BIRTNPLACE (State or Foreign 8. 1 M 2 X F YRS. N/A Feb. Maryland Pages 1, 2, 3 should se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Rodgers Forge 1 YES 2 NO permit 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 138 Stanmore Road hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit 21212 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1) Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rici 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION Visician and completely filled in by the funeral director, page 5 should be detached for use prior to burial, cremation, or removal. 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) COMPL N/A N/A N/A once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at Robert Carroll Thompson BE Deborah Dorn Ann 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert Thompson 138 Stanmore Rd. Baltimore, Maryland 21212 must be 20a. METNOD OF DISPOSITION
1 Surial 2 Cremation 3 R
4 Denotes 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Stablers Church Cemetery 2-12 Parkton, Maryland the medical examiner ATURE OF FUNERAL MENVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximata Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) PORIGSTIC hours traumatic event. DUE TO (OR AS A CONSEQUENCE OF) requires that the death certificate be executed ulmonary 25 hours CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF signed by the attending physician Health and Mental Hygiene prior to DIA MARA MANO cause. Enter UNDERLYING CAUSE (Disease or injury other that initiated events resulting in death) LAST injury, or PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TYES 2 NO 1 YES 2 PHO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN THE NOING PHYSICIAN: The law this certificate has be with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: 1 TES 2 TAO Inpatient 2 - ER/Outpatient 3 -4 Nursing Nome 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 26s. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY After 2 Accident Suicide 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 🗌 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) If item-28 is COMPLETED 4 Homicide OR A 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FLINEHAL
TO THE FLINEHAL
Be filed were 774
IMPORTANT: If It 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Your Laure nzu 140 MD 043577 > February 1996 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) "N Wolfe St Balhusure, 40 600 -awrence M. Nogee MD 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 3 1996

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Please Type or Print in Black Indelible Ink. Assure All Copies Are I acible ITEM: 3796 PER F.H. FILM G-732 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year RHODA V THACKER FEB 9 1996 0114 /Medical 4a. Facility Neme (If not institution, give street end number) 4h City Town or Location of Deeth 4c. County of Deeth Examiner UNIVERSITY OF MARYLAND HOSPITAL Balto.City, Md. none | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State of Country) | Feb. 26, 1934 | Kentucky 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 10 M 3/F 61 Yrs. Director 404-44-2887 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Director t√ Yes 2 No Balto.City, Md. Maryland none 10e. Street and Number 10g. Citizen of What Country? 6 1233 Washington Blvd. 21230 Nome 23a United States Funeral 11. Marital Status SEPARATED 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 6 1 ☐ Yes 2 1 No Specify: by Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) marked other then Elementary/Secondary (0-12) College (1-4or 5+) Inspector Operator Ketema 12th.Grade none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Peges 1 and 2 should be nent of Heelth and Mental Collier Barnes 19e. Informant's Neme/Relationship (Type, Print) The Health and The High and The High Man Annual High Man Annua 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. Troy M. Thacker 1249 Washington Blvd.Balto.Md.21230 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If any Injury or once. 5 Other (Specify) Cedar Hill Cemetery2/12/96 A.A.Co.Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Balto.Md. 21230 McCully Funeral Home, 130 E. Fort 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each inner. Approximete Interval Between Onsat and Death **Physician** Immediate Causa (Final CORONARY ARTERY DISEASE diseese or condition resulting in death) Examiner Due to (or es a consequance of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of) Physiclan/Medicai Due to (or as e consequença of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ned by 1 Yes 2 No 3 Probably 4 Unknown Sign. ρ 24b. Were autopsy findings aveilable prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy 1 Yes 2 No the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖔 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1X Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Atheir 5 Pending Investigation 1 X Naturai 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) after Dire 4 Homicide 24 hours edical 16 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, end due to tha causa(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Cartifier completely within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

Vital cian:

Divisional

å,

Hospital

the Marylend

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

31. Date filed (Month, Dey, Year) State Registrar

KUU

DICK

22. S GREENE ST. BALTIMORE, MD #21201 32. Registrar's Signature Jalin attender Karlell

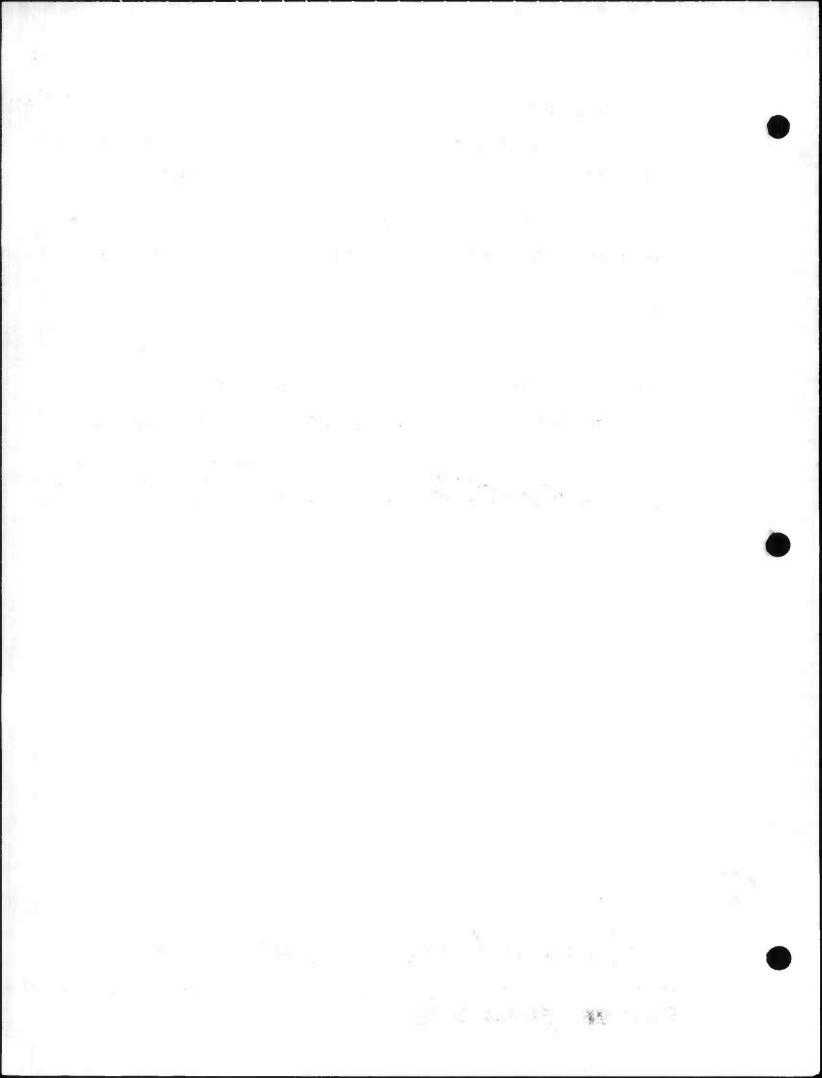
30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

96

a Agragager of grant grant grant grant

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene 96 036 17

| | | | | | $C\epsilon$ | ertificate o | f Death | | Reg. No. | | | |
|--|--------------------------|----------------|---|--|--|---|----------------------------------|--|---|-----------------------------------|---------------------|--|
| Dh | ysicia | n | 1. Decedent'a Neme (First, Middle, La | ast) | | | | 2. Dete of I | Deeth Dey | Yeer | 3. Tin | n Death |
| | ysicia Vedic | _ | THEO WILLIA | | | | | 2 | 12 | 96 | . 9 | 1 |
| Ex | amin | er | 4e. Fecility Neme (If not institution, given | ve street and number) | | | | m, or Location of De | ath 4c. Coun | ty of Deeth | | |
| | _ | | 2537 WEST NO | | | If Under 1 Yes | | IMORE | | TIMOL | | CITY |
| Fun Dire | | | | Sex 1□M 2∏ F | (In yrs. lest birthday 82 Yrs. | Months Dey | | | 20, 191 | 9. Birthp | piece (Str 14ry) | tete or Foreign |
| Mand | 16 | ŀ | 10e. Stete 10b. County | | 10c. City, Town or L | ocation | | | | 1 | IOd. Insid | de City Limits |
| e Man | office | Director | MD BALTO. | CITY | BALTIM | ORE | | | | | 1 🕅 | Yes 2□No |
| with th | If De no | Dire | 10e. Street end Number 2537 WEST NOR | TH AVENU | JΕ | 10f. Zip Code 2 1 2 1 | | | 10g. Citizen of UNITE: | | ntry? | 5 |
| death | 3 | Funeral | 11. Meritel Stetus | 12. Wes Decedent E | ver In U,S. 13 | . Wes Decedent o | f Hispenic Origi | In? (Specify Yes or I Puerto Rican, etc.) | No- 14. Re | eca - Americ | | en, |
| hours after death with the Maryland ural', or flems 23s or 28s-f show | Examine | 2 | 1 ☐ Never Merried 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: | 0 | 1 □ Yes 2 N | | Puerto Hican, etc.) | Spec | eck, White, ^{/fy:} BI | etc. LACK | ζ |
| 72 hours netural', | dicel | etec | 15. Decedent's E (Specify only highest gro | ducation ade completed) | 16a. Deci | edent's Usuel Occ e kind of work dor | supetion ne during most | of working | 16b. Kind of | Business/în | dustry | |
| within ana. than | the Medical | Completed | Eiementery/Secondary (0-12) | College (1-4or 5- | life. | DO NOT use reti | ired) | • | WHOLE | SALE | BAF | KERY |
| | event, b | Ö | 17. Fether's Neme (First, Middle, Last |) | | | 18. Mother | 's Name (First, Midd | | | | |
| D TO | tic ev | To Be | LUCIOUS BONA | PARTE | | | GUSS | SIE HINE | S | | | |
| nd 2 salth ar 27 ls | other trsumatic | | 19e. Informent's Neme/Reletionship (GUSSIE STEWAR) | | | ling Address (Stre INOLE A | | or Rural Route Num BALTIM | ORE, M | | Code) 1229 |) |
| m 0 - | or of | | 20e. Method of Disposition 1 ABunel 2 Cremetion 3 C | Removei trom Stete | 20b. Plece of Disp cemetery, cre | position (Neme of smetory or other p | lace) | Dete | 20c. Location | | | te |
| tman | duy | | 4 ☐ Donetion 5 ☐ Other (Specif | (y) | | BURN CH | | 2-16-9 | 6 BAL | то., | MD | |
| permit. Page Department of Important: If | any Injury once. | | 21. Signeture of Funeral Service Lice | adla | / | Z. Name end Add | | | 70 FRE | DHILT BALT | | PASS MD |
| Satisficate be associated by Satisficate by Satisfi | ical ner private transit | Medica | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | . ATM | Due to (or as a consecutive to (or es e consecutive to | ENDS equence of): ESTETO | | | 20BABI | | | MINUTI YEAR YEARS |
| that the death | etached fo | Physician | Pert II. Other significant conditions of | contributing to death but | not resulting in the | underlying cause | given in Pert I. | | d tobacco use c | | | use of death? |
| v requiras been sign | 2 | Completed by | | | | | _ | | es en eutopsy normed? | ev co | aileble pi | psy findings prior to n of cause |
| The lav | director, page | E | | | | | | 10 | Yes 20 No | 10 | □Yes | 2 No |
| ilcian: The | ctor, | | 25. Wes case reterred to medical examiner? | | | | 26. Place | of Deeth (Check only | y one) | | | |
| Physician: r this cartific | e la | 0 | 1 Yes 2 No | Hospitei: 1 Inpatien | t 2 ER/Outpatie | ent 3 DOA | Other: 4 Nurs | sing Home 5 8e | sidence 6 🗆 O | ther (Specif | <i>y</i>) | |
| inding P | funeral | TION: | 27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation | 28e. Dete of injury (Month, Dey | Year) 28b. Time (| W | juryat /ork? □Yes 2□N | | e how injury occu | urred | | |
| any Attan any des | d gov me | Certification: | 3 Sulcide 6 Could not b | e 29a Diago et Inius | ry - At home, ferm, a (Specify) | | | 28t. Location | (Street end Nurr own, Stete) | nber or Rure | I Route | Number, |
| Pulous Fulous | alay ii | | 29e. Certifier (Check only one) 1 Cartifying Ph 2 Medicat Exam | nysician: To the best of niner: On the basis of e end menner stete | examinetion end/or in | th occurred at the nvestigetion, in my | time, dete end opinion, deeth | pieca, end due to the courred et the time | e cause(s) end me, det <i>e e</i> nd pl <i>e</i> ce | nanner as s , and due to | tated. | 180(S) |
| Withir To th | | - | 29b. Signature and title of certifier | Λ Λ | . 0 | 29c. Lice | nae number | | 29d. Dete sign | ed (Month, | Day, Ye | ar) |
| | | | held | UM A | Msex | DI | 634 | 7 | 2 | 13/ | 96 | |
| | | | 30. Name end eddress ot person who | completed cause of dec | | - | | | | | | |
| | | | SHELDON A | | 10,86 | 1 PAR | KAI | JE ! | BALTIM | ore. | 40 | 21001 |
| Do | State | - | FEB 1 3 1996 | 22. Registrar | s Signeture | • | | | | | | |
| He | gistra | r II | 1 70 19 19 19 | and hand bearing | howarder . | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 96 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month DAIS 12 noon 96 4b. City, Town, or Location of Deeth 4s. Feclifty Neme (If not institution, give street end number) 4c. County of Deeth Balto Midwood YAE 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 1□M 20 F - 03 - 4229 95 Yrs. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 12XYes 2□No Md. 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 5004 AVE. 21212 11.5-4 Midwood 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 1 No Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife gin GRACK 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JAMES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROWN 51 ANNAPOLIS Md. 21401 MARGARET IPd Hedy 20b. Plece of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cometery, cremetory or other pleca, 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licansee das bese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest re. List only one cause on each line. Approximate Interval Between Onset and Deeth immediate Cause (Finel disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es s consequence of) Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobscco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 1 Neturel 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred

Examiner attending physician and for usa as the burial-transit The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, 2 eged

Examiner Physician/Medical Ď Completed certificate has Be ٢ Certification:

Physician

/Medical

Examiner

Director

Funeral

2 Q

Completed

Be

Funeral

Director

Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be nothed at

permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene,
Important: if Item 27 is marked other than "natu
any injury or other traumatic event

Physician

/Medical

. or h

with the Maryland

3altimore, Maryland 21215-0020

the Hospital or Attending Physician: ' hin 24 hours after death. the Egneral Director: After this carifica inpletely filled in by the funeral director, g

Medical 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

1 Yes

1 Certifying Physicisn: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

d cause of deeth (item 23a) (Type, Print) 10755

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

31. Dete filed (Month, Dey, Year) State FEB1 3 1996 Registrar

2 Accident

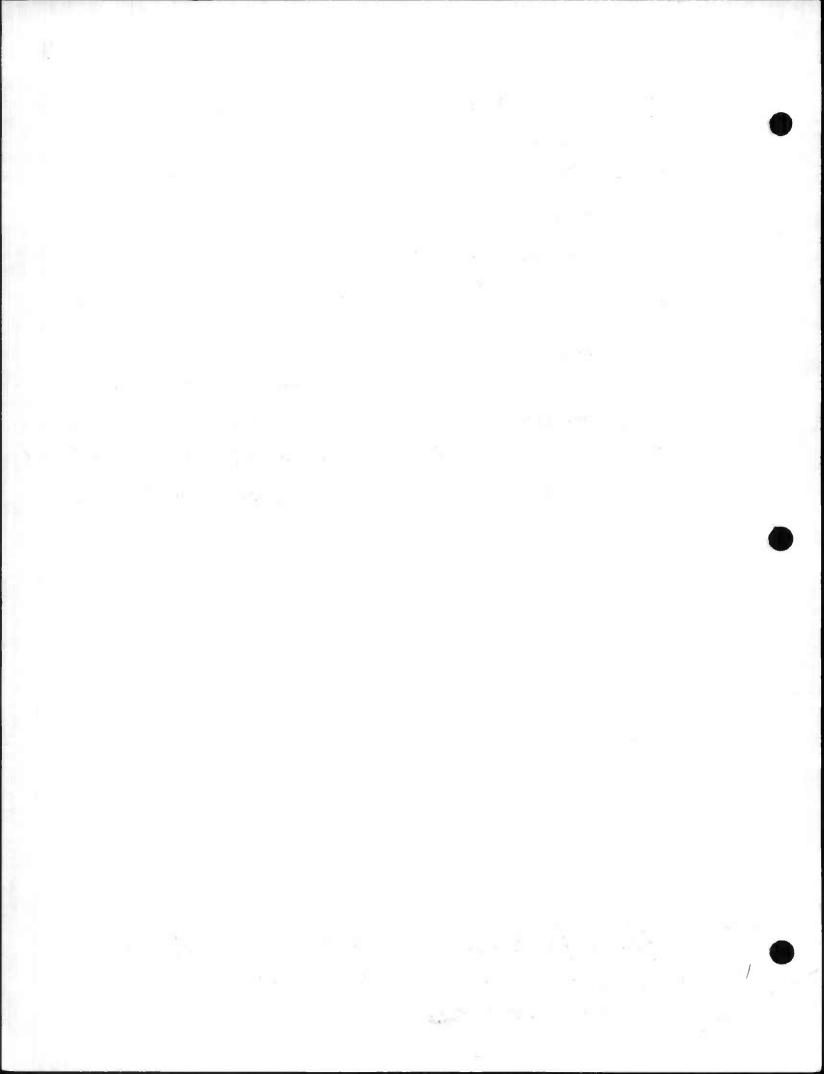
3 Suicide

29e. Certifier

4 ☐ Homicide

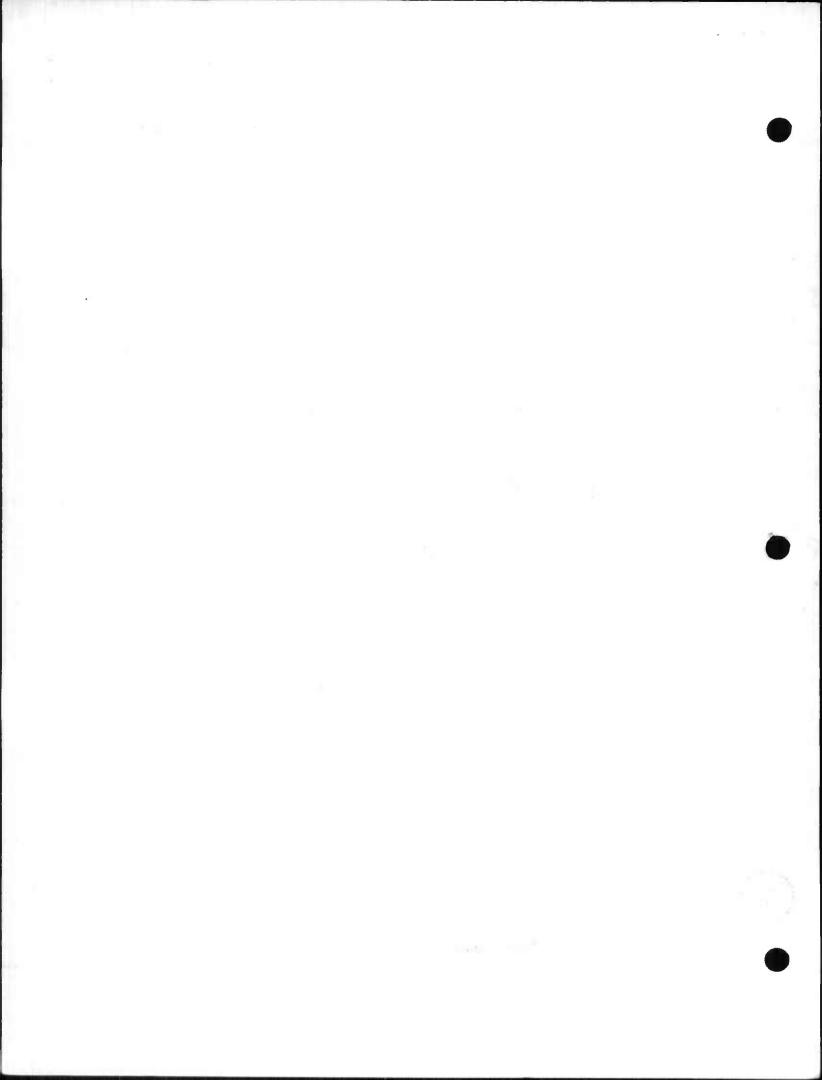
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| - 10 | 1 - STATE REGISTRAR | STATE OF MAR | | ERTIFIC | AIE | OF DEATH | REG. NO |) | | | | | | |
|------------------------------|---|--|---|--|--|---|---|---|----------------------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | | | | | | | | YEAR | TIME OF DEATH | | | | |
| 1 | BLUMAE 4. SOCIAL SECURITY NUMBER | | YNN AGE (In yrs. I | est birthdey) | F UNDER 1 Y | EAR IF UNDER 24 HRS. | FEB 7. DATE OF BIRTH | 6 19 | | 10:45 P | | | | |
| | 216-20-2496 | 1 M 2 X F | 82 | YRS. | ONTHS D | AYS HOURS MIN. | (Month, Day, Year) 1-2-191 | 4 | Country) | N.C. | | | | |
| OR | 96. FACILITY NAME (If not institution, give MERCY HOSPITAL | street and number) | | 9 | BALT | IMORE | EATH | | IMORE | CITY | | | | |
| ECTOR | RESIDENCE OF DECEDENT 10s. STATE 10b. COUN | TY | | 10c. CITY, | TOWN OR I | OCATION | | | 100 | I, INSIDE CITY | | | | |
| DIR | MD BAL | TIMORE CITY | | | TIMOR | | | | | LIMITS? YES 2 NO | | | | |
| ERAL | 100. STREET AND NUMBER 1600 MT. ROYAL A | \VE | | | | 10f, ZIP CODE | | | | T COUNTRY? | | | | |
| FUNE | 11. MARITAL STATUS | 12. WAS DECEDENT EX | ER IN U.S. A | RMED | 13. WA | 21217 | NIC ORIGIN? (Specify V | | S.A. | American Indian, | | | | |
| B∀ | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 [] | 1 VES 2)(_NO If yes, specify Cuben, Mexic WAR OR DATES 1 YES 2 XNO Speci | | | | cen, Puerto Ricen, etc.) Black | | | BLACK | | | | |
| TED | 15. OECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE HOSPITAL (DOC | | | | | | | | | | | | | |
| PLET | Elementary/Secondary (0-12) | " | NURSE | | | HOS | PITAL | (DOCT | OR OFFI | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (First, Middle, Maide | | (000) | 011 011 10 | | | | |
| BE | WILLIAM D. GRA | | | | | E COLE | | | | | | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) LIZZIE WOINGUST 191. MAILING ACORESS (Street and Number 814 BARRE STREET) | | | | | | | | Code) | | | | | |
| | 204.,METHOD OF DISPOSITION | | | EAND OATE OF | OISPOSITIO | ON (Name of | DATE 20c. L | OCATION — C | | | | | | |
| | 1 XBuriel 2 Cremation 3 Rs 4 Donation 5 Other (Specify) | | ELMW | OOD CE | METE | RY 2/11/96 | GOL | DSBORO | ,NOR | TH CAROL | | | | |
| | 21. SIGNATURE OF GENERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 | | | | | | | | | | | | | |
| | 23. PART I. Enter thy diseases, o | complications that ca | used the | death. Do no | | | | | | Approximata | | | | |
| | IMMEDIATE CAUSE (Fins) | a. List only one cause | | | | | | | | interval Bety Onset and D | | | | |
| | disease or condition reaulting in death) | | | EQUENCE OF): | | Bines | | | | 10 m | | | | |
| NO | | ъ. | | | | | | | | | | | | |
| ATIO | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| RTIFICATI | CAUSE (Disease or Injury CAUSE (Disease or Injury that initiated avents DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| ш | resulting in death) LAST | | | | | | | | | | | | | |
| 0 | 0. | | | | | | | N AUTOPSY | 24b. WI | RE AUTOPSY FIND | | | | |
| EDICAL | g | | | | | | PERFO | PRMED? | CC | AILABLE PRIOR TO IMPLETION OF CAU DEATH? | | | | |
| | | | | | | | | | | YES 2 NO | | | | |
| ME | DID TORACCO HEE CONTRIBUTE TO CAHEE OF DEATH VES TO NO SE HINCEPTAIN TO | | | | | | | | | | | | | |
| 2 | | 25. WAS CASE REFERRED TO MEDICAL EXAMNER? HOSPITAL: OTHER: | | | | | | | | | | | | |
| SICIAN: M | 25. WAS CASE REFERRED TO MEDICAL | | | | | Home 5 Residence | 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 N Other (Specify) F | | | | | | | |
| SICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 I Es | NOutpatient | 3 🗆 DOA 4 | OF 26 | | | HOS | | | | | | |
| AN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 1 Inpatient 2 EF 28s. DATE OF INJ (Month, Day. | NOutpatient IURY Ibar) | 3 DOA 4 | OF 26 | c. INJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCC | URED | | | | | |
| ED BY PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 EF 28e. DATE OF INJ (Month, Day. 28e. PLACE OF IN | R/Outpatient IURY Year) | 3 DOA 4 | OF 26 | c. INJURY AT WORK? | | INJURY OCC | URED | a Number, | | | | |
| ETED BY PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined | 1 Inpatient 2 EF 28e. DATE OF IN. (Month, Day. 28e. PLACE OF 19 | R/Outpatient IURY I/ber/ IJURY — At (Specify) | 3 DOA 4 26b. TIME INJUI | OF 26 RY M | ic. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW 28f. LOCATION (Stree City or Town, Stef | t and Number (| ORED or Flural Flout | a Number, | | | | |
| ETED BY PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHY | 28e. DATE OF IN. (Month, Day. 28e. PLACE OF the building, etc. | N/Outpatient IURY Idear) AJURY — At . (Specify) | 3 DOA 4 28b. TIME INJUI home, term, str | OF 26 RY M eet, tectory | c. INJURY AT WORK? 1 YES 2 NO , office | 28d. DESCRIBE HOW 28f. LOCATION (Stree- City or Town, Stell | t and Number (e) | or Rural Rout | | | | | |
| COMPLETED BY PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHY | 28s. DATE OF INJ (Month, Day.) 28s. PLACE OF the building, etc. /SICIAN: To the best of my NER: On the basis of sxem | A/Outpatient URY Idear) JURY — At (Specify) knowledge, illnation and/o | 3 DOA 4 28b. TIME INJUI home, term, str | OF 26 RY M eet, tectory | c. INJURY AT WORK? 1 YES 2 NO , office b, date and placs, and du- ulon, death occured at the | 28d. DESCRIBE HOW 28f. LOCATION (Stree City or Town, Stef to the cause(s) and m time, data and place, to MBER | t and Number of solutions of the state of the solution of the | or Rural Rout ed. e cause(a) as | od manner as state | | | | |
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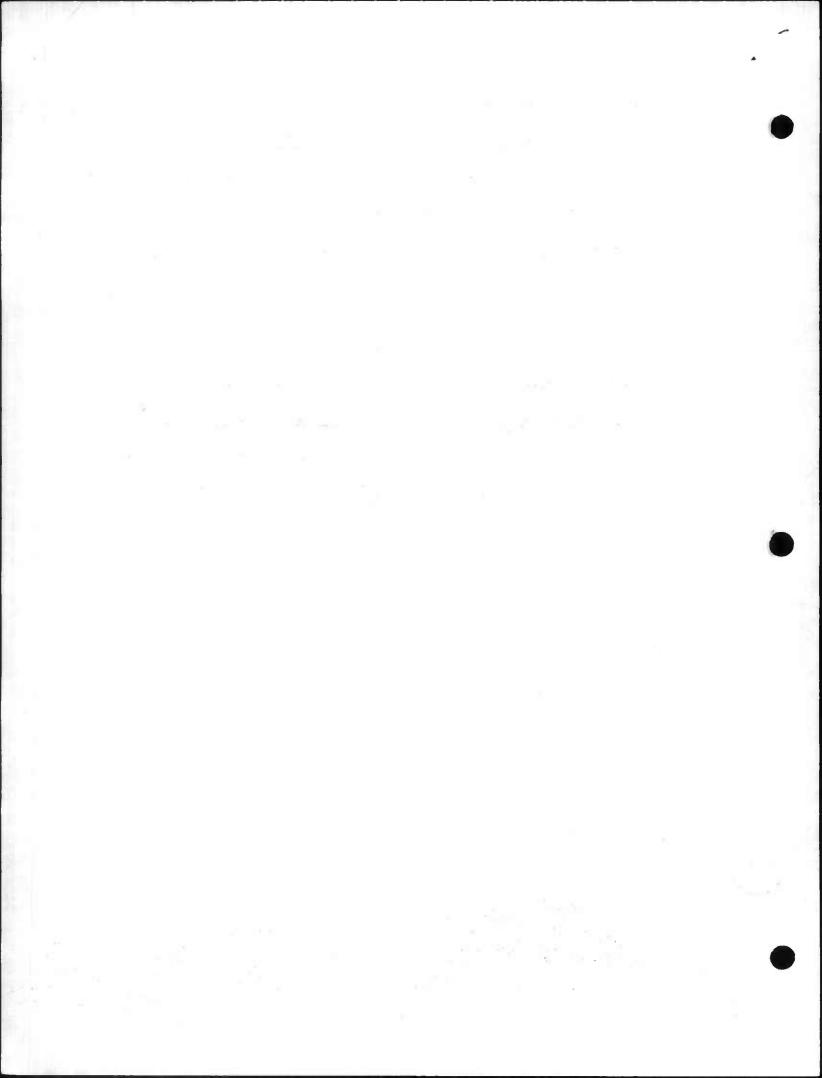


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State of Maryland / Department of Health and Mental Hygiene 96 03620

| | | 1. Deceden | t'a Nama (First, Middle, L | Last) | | | | Death | 2. Date of De | Reg. No. | | 3. Time of Death | |
|--|---|--|--|---|--|--|---|---|--|--|--|--|--|
| | sician | E | DWARD | WRIGHTSON | | | | | Month Februar | Day | Year | 5:00 P.1 | |
| | edical miner | de Carilla d | Name (If not institution, g | | | | | b. City, Town, or | | | unty of Death | 3.00 1.1 | |
| Exam | mmer | | 519 Danvill | | | | | Baltimor | | | I/A | | |
| Funera | _ | 5. Social Se | | Sex 7. Age | (In yrs. last bir | thday) If Unda Yrs. Montha | r 1 Year Days | If Under 24 Hrs. Hours Min. | | h y, Year) | - | placa (State or Foreigntry) | |
| D . | | | lence of Decedent | | | | 1 | | | | ratt y | Larka | |
| e Manylar | ctor | Md. | 10b. County N/A | | 10c. City, Tow Balti | | | | | | 1 | 0d. Inelde City Limit | |
| 23a or 28 | Funeral Director | 10e. Street 651 | and Number 9 Danville | Avenue | | 10f. Zip 2 | Code 1224 | | | 10g. Citizan USA | of What Cour | What Country? | |
| filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or terms 23a or 28e-f show ant, the Medicial Examiner must be notified at | by Funer | 3 □ y vid | Status ar Married 2 Married owed 4 Divorced | 12. Was Decedent E Armed Forces? 1∑ Yes 2 □ No If Yas, Giva Year or Dates: | | 13. Was Decedif Yes, spe | | ispanic Origin? (S an, Mexican, Puart Specify: | pecify Yas or No o Ricen, atc.) | | Race - Amaric Biack, White, ecilWhite | etc. | |
| thin 72 hours e. en "netursi", Medical Exe | pet | | 15. Decedent's I (Specify only highast g | Education | 16a. | Decedent's Usu | al Occup | ation during most of wor i) | rkina | ing 18b. Kind of Business/ | | dustry | |
| filed within Hygiene. | 6 | Eiementa | ry/Secondary (0-12) | College (1-4or 54 | | Chauffer | | during most or word) | King | Taxio | cab | | |
| be filed d other | Be | 17. Father's | Name (First, Middle, Las | * | | | | 18. Mother's Name (First, Midd | | | nema) | | |
| should b nd Ment marked umatic e | | | | | | | Mary Thleo | | | , | | | |
| | | 19e Inform | ant'a Name/Relationship larlesa Gold | Coldberg Daughter | | 19b. Malling Address (Stree 6519 Danvill | | | | | | Code) | |
| | | 1 D Bui | of Disposition rial 2 Thermation 3 nation 5 Other (Special Control of the Contr | ☐Ramoval from State | Disposition (Nairy, crematory or C | ther plac | | 20c. Location - City or Town, Stata Baltimore, Md. | | | | | |
| permit. Pages 1 Department of F Important: If its any injury or ot | DUCE. | | re of Funeral Service Lice | | (2) | 22. Nama ar | nd Addre | ss of Facility | | | | | |
| 007 8 | Charles S. Zeiler 6224 Eastern Aver 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as card shock, or heart fallura. List only one cause on each line. | | | | | | | | | | | | |
| ficate be asscuted by physician and set the burlat-transit | Tedical Examiner | disease or o | Cause (Final condition | Car | -dis | e 0 | ca | hutt | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 2 | | Approximata Interval Between Onaet and Deeth | |
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| fing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a: | To Be Completed by Physician/Medical Examiner | Sequentiallif any, leadicause. Entitle Cause (District Interest of the Cause) of the Cause (District Interest of the Interest | v list conditions, or to immediate or Underlying asse or Injury levents death) Last r significant conditions r referred to medical or to be the conditions of Deeth conditions of Deeth conditions of Deeth conditions or to be the conditions of Deeth conditions or to be the conditions of Deeth conditions or to be the conditions of Deeth conditions or to be the conditions of Deeth conditions or to be the conditions of Deeth conditions or to be the conditions of Deeth conditions or to be the conditions of Deeth conditions or to be the conditions of the conditions or to be the conditions of the conditions or to be the conditions of the conditions or to be the conditions of | b | Due to (or as a count of the co | consequence of): consequence of): the underfying of | DA Oth Page. Injur | en in Part I. 26. Place of Decer: 4 \(\) Nursing H | 23b. Did 1 1 24a. Was perfo | obacco use yee 2 N an autopsy med? 'as 2 N anoe 6 D | contribute to 3 Proi 24b. Wo | the cause of death the bably 4 Unknown of causa daath? | |
| Attending Physician: The law requires that the death certify redeath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a: | To Be Completed by Physician/Medical Examiner | Sequentiallif any, leadicause. Enk Cause (Distribution of the cause) Part III. Other | e referred to medical relations to the conditions of the conditions, and to immediate or Underlying base or Injury levents death) Last The referred to medical relations of Deeth and investigation of Could not condition to the conditions of the c | b | Due to (or as a composite to the composi | consequence of): consequence of): consequence of): the underlying of the underlying of niury M | DA Oth DA Oth Wor 1 | en in Part I. 26. Place of Decer. 4 Nursing H | 23b. Did 1 24a. Was perfo 1 1 ath (Check only coloma 5 Residence of the coloma 5 Residence of | obacco use yee 2 N an autopsy med? Yas 2 N we) Jance 6 D now Injury oc | 24b. W av co of 0 1 Cother (Specification) | the cause of death bably 4 Unknown under autopsy findings allable prior to mpletion of causa daath? | |
| Attending Physician: The law requires that the death certify redeath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a: | Certification: To Be Completed by Physician/Medical Examiner | Sequentially if any, leadicause. Entropy in a cause. Entropy in a | e referred to medical relations of Deeth aral sides and to medical for the conditions of the condition | b | Due to (or as a computed to to a second to the computed to the | consequence of): consequence of): consequence of): the underfying of the underfying of niury M m, street, factory | DA Oth Page injury Oth y, office | en in Part I. 26. Place of Decer: 4 Nursing H | 23b. Did in the 24a. Was performed to the control of the control o | obacco use Yee 2 N an autopsy med? (as 2 N anow Injury oc Street and N m, State) | 24b. W. av. co. of 0 1 [| tated. | |
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 96 0362

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Vost 9:20 AM ances reb 1996 12 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner to Da nes If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth Month, Day, MAY 5. Sociel Security Number 7. Age (In yrs. iest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 201F 212-30-6656 Yrs Director 70 Va Usuei Residence of Decedent the Merylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director Md Batto 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? HISG uith 61202 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. 11. Meritel Stetus permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or then any injury or other traumatic avant 1 Never Merried 2 Married 1 Yes 2 If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify þ 3€ Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Nursing ASSIST. Health 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Samble Alease Austin 2 trank 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Shirley Winfree Sumpter S.C ANN St. tulton 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Balto. MT. Zion 4 ☐ Donetion 5 ☐ Other (Specify) 13 Signature of Funeral Service Licanses 22, Neme end Address of Fecility Sons Morto Ŝŧ James Balto, Md. 21217 1701 Laurens diseese, or complicate feilure. List only one pplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Stroke o days diseese or condition resulting In death) Examiner Due to (or es e consequence of): Examiner Heart Failure onge stive **bunel-transit** Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): physician a the bunel-Box 68760. Physician/Medical Due to (or es e consequença of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contributs to the cause of death? 3 Probably Onknown signed by 1 ☐ Yes 2 ☐ No Sticke Division of Vital Records, by 24a. Wes en eutopsy performed? 24b. Were autopsy findings evallable prior to Completed congesture peen HEAT completion of cause of deeth? hes 1 Yes 2 No nemia 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: " within 24 hours after death." To the Fameral Director: After this certifica 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 Yes funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Medical Certification: 5 Pending Investigation 1 PNetural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Metaly filled 1 Lectifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner as stated. 29e. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29b, Signature 17th title of certifie 29c. License number 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Siv. lley 900 Caton Ave + 2

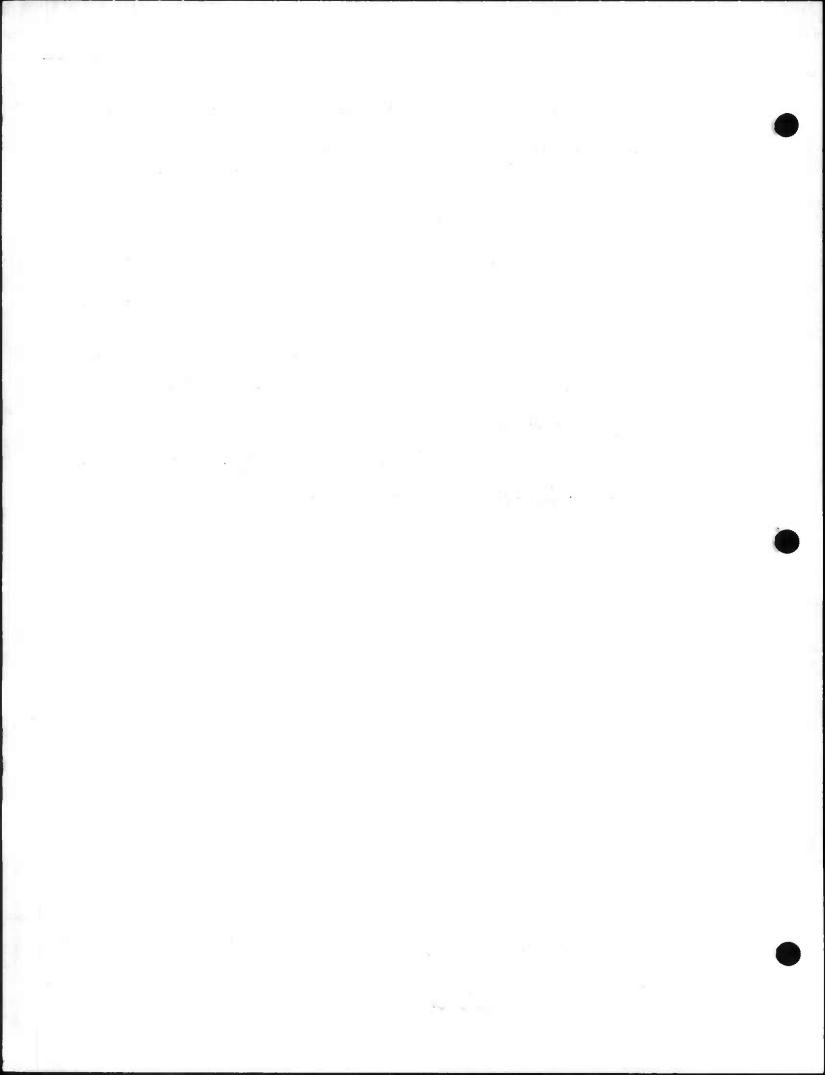
DHMH 16 Rav 6/95

State

Registrar

31. Dete filed (Month, Dey, Year)

FEB 1 3 1996



Physician /Medical **Examiner Funeral**

Director

the Marylend 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at with death

pernit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite other t any injury or c

altimore, Maryland 21215-0020

Physician /Medical Examiner

physician and s the burial-trans 980 for ed by the a signed by 8 funeral director, After

Box 68760 P.O. Division of Vital Records. at or Attending Physician; safter death. To the I

4c. County of Deeth JOHNS Moglans Bayview nuderal Center MO BALAMORE If Under 1 Yeer 5. Sociel Security Number If Under 24 Hrs. 8. Sex 7. Age (in yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) 111 M 2□ F Yrs 216-16-2411 72 Maryland Usual Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits Md. **Baltimore** 1 Yes 2 No Halethorpe Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3008 Penna Ave. 21227 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 43–45 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) Eastern Stainless St. Shipping Department 6th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) William W. Webb Arlene Martz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Florence Marcantoni 6821 Fordcrest Road BAltimore Md. 21237 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Removel from State Gardens of Faith 2/12/96 4 ☐ Donetion 5 ☐ Other (Specify) Rossville Md. 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the daeth. On not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List ply one cause on each line. Approximete Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) cardiac ames more Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resuiting in deeth) Last Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? hypertoaquilable tate, CMF, failure 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No ģ 24a. Wes en autopsy performed? 24b. Ware autopsy findings aveilable prior to completion of cause of death? Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Menner of Death Data of Injury 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury of Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Ragistrer's Signeture

Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

E Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner stated.

29c. License number

JOHNS KOPLINS BAYVEN Med OR 4940 EASHERN ST Signeture AVE., BALTIMORO, WO 2/224

28f. Location (Street end Number or Rural Route Number, City or Town, State)

State Registrar

Medical

3 Sulcide

29a. Certifier

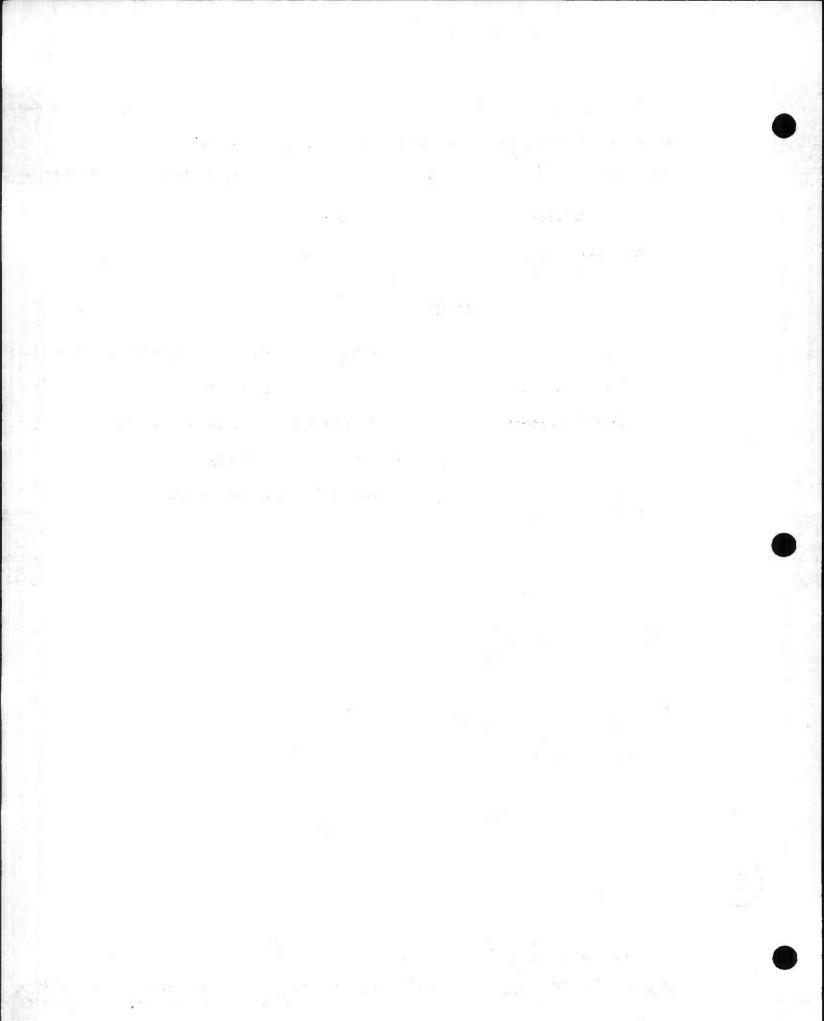
4 Homicide

(Check only one)

29b. Signeture and title of certifier

31. Dete filed (Month, Day,

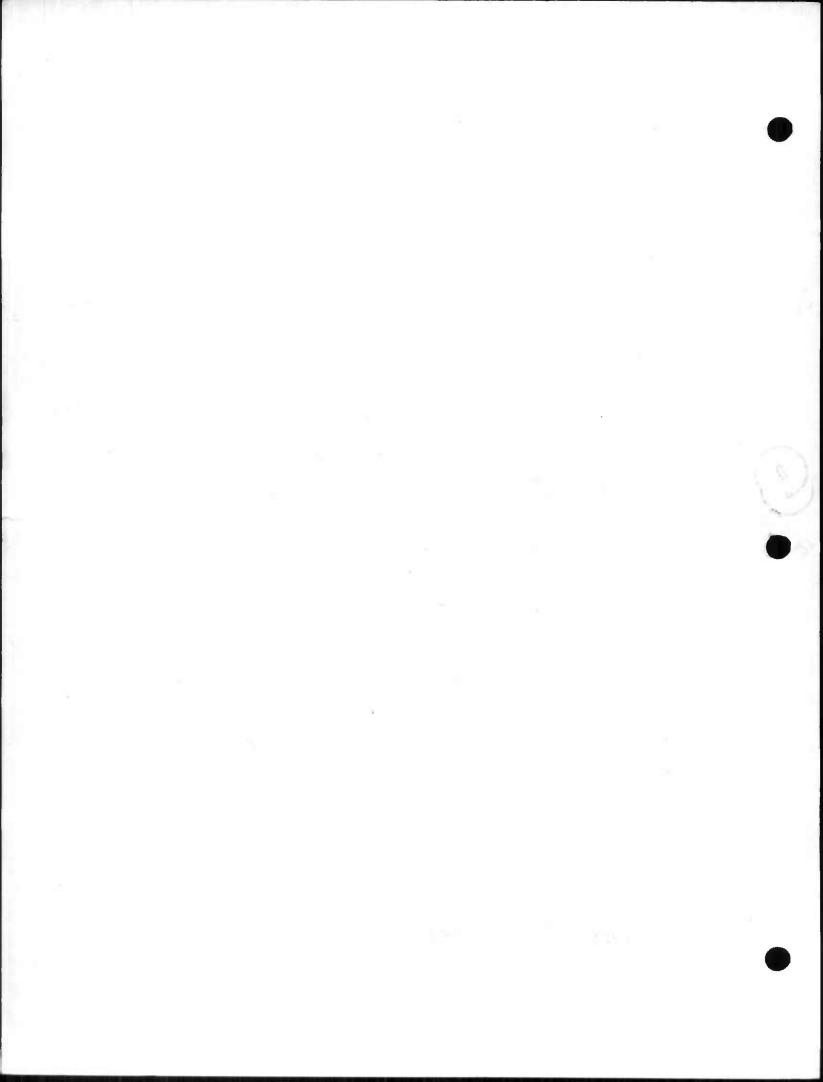
30. Name and eddress of person who completed causa of death (Itam 23a) (Type, Print)



MGRE, MARYLAND 21215-0020

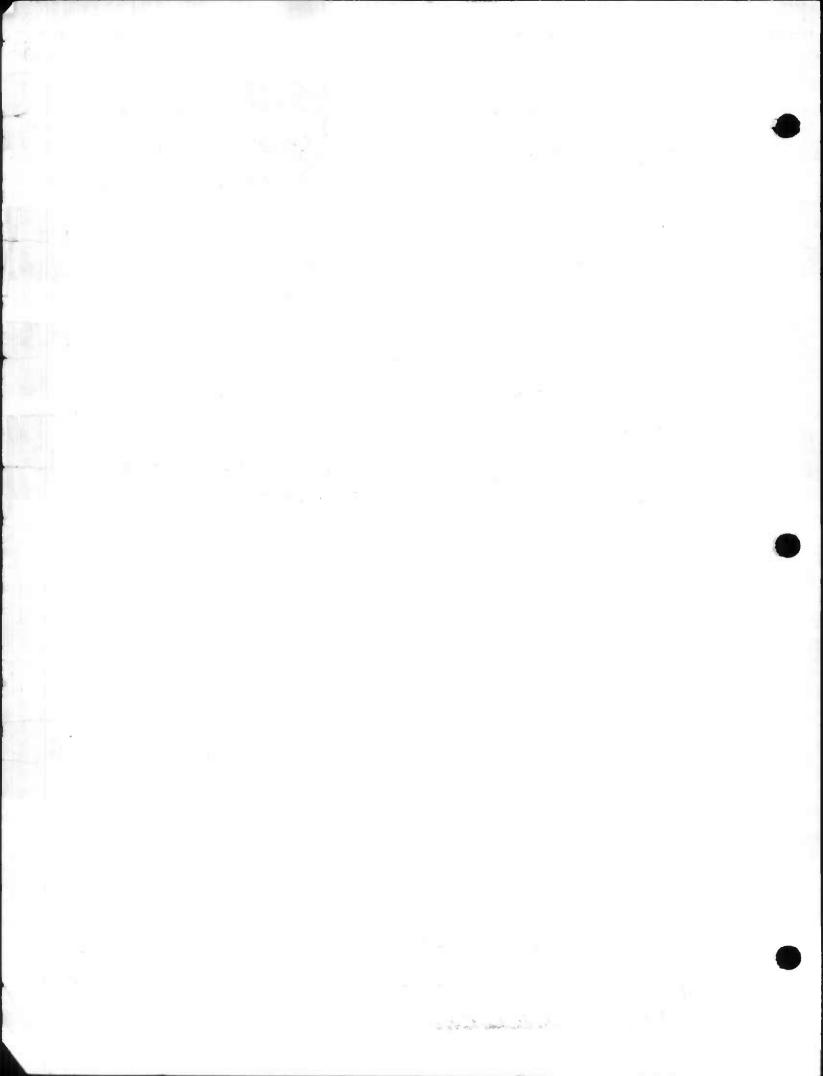
DIVISION OF VITAL RECORDS, P.O. BOX 6876

| | 1 - STATE REGISTRAR | STATE OF MARYLAND | D / DEPARTM | | | | YGIENE | | |
|--|---|---|----------------------------|-----------------|-----------------------------|--|-----------------------|------------|---|
| 2000 | 1. DECEDENT'S NAME (First, Middle, Lest) Charle. S | Zepf | | | | 2. DATE OF D MONTH Fe.b. | | 79G | 3. TIME OF DEATH 9:25 PM |
| | | SEX 6. AGE (In yrs | YRS. I last birthday) IF I | THE DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BI (Month, Day, 6/29) | PTH Y66/) / 1920 | Countr | IPLACE (State or Foreign y) ryland |
| œ | 9a. FACILITY NAME (If not institution, give street | and number) | 9b. | | R LOCATION OF DI | EATN | 9c. CO | UNTY OF D | |
| 010 | Stella Maris | | | Ba1ti | | | | N/A | |
| DIRECTO | Maryland N/ | 'A | | wn or locat | | | | | 10d. INSIDE CITY LIMITS? 1 XYES 2 NO |
| | 10e. STREET AND NUMBER | | | | ZIP CODE | | 10g. Cl | TIZEN OF V | VNAT COUNTRY? |
| FUNERAL | 1022 Key Highw | | 101150 | 40.000 | 21230 | | | | d States |
| IF YES, GIVE WIRD OR DATES 1 YES ZY NO Specify: Specify: | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| COMPL | 11 | | Sales | | | | Constru | cti | on |
| | 17. FATNER'S NAME (First, Middle, Lest) Charles R. Zep | n Sr | | | | Stay] | , Maiden Surname) | | |
| O BE | 19a. INFORMANT'S NAME (Type/Print) | p, 31. | 19b. MAILING ADD | RESS (Street a | V TOTA | | | (ip Code) | 21227 |
| ř | C. Raymond Zep | | | | | - T | | - | |
| | 20a. METNOD OF DISPOSITION 1 Strict 2 Cremation 3 Removal 4 Donation 5 Dother (Specify) | trom Statemetery | CEAND DATE OF DI | viace) | | DATE | 20c. LOCATION - | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | Mea | dowridg | 22 NAME AN | orial ose Fu | CILITY DOT 2 | Homo | Tna | aryland • Arbutu |
| | Ineles ! | (Je | 2 | | Sulph | | | | 21227 |
| 7 | 23. PMT I. Enter the diseases, or com shock, or heart failure. List | plications that caused the only one cause on each | death. Do not e | enter the mo | de of dying, aud | ch aa cardiac | or reaplratory a | rreat, | Approximata interval Between |
| 1 | IMMEDIATE CAUSE (Fine) disease pr condition resulting in death) | Lung Co | Lncer | | | | | | I month |
| _ | | | | | • | | | | 1 month |
| | I if any, leading to immediate | Esophagea DOE TO (OR AS A COP | | | | | | | |
| RTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in death) LAST | Brain Met | ASTASE NSEOUENCE OF): | 25 | | | | · | IMonth |
| | d | | | | | | | | |
| MEDICAL | hepatic C | ontributing to death but in | ot resulting in th | ne underlying | ceuse given in | | PERFORMED? YES 2 PHO | 246 | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| | DID TOBACCO USE CONTRIB | SUITE TO CAUSE OF C | FATH YES | NO E | UNCERTAI | N [] | | | 1 TYES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 26. F | PLACE OF DEATH (C | check only one) | ONCERIA | | | | |
| Ž. | 1 TYES 2 THE NO 1 | OSPITAL: Inpatient 2 ER/Outpatier | 1 3 DOA 4 | | s 5 Residence | 6 T. Other (Spe | E NOW INJURY O | e at | Hercy |
| > I | 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | WO | URY AT RK? 'ES 2 NO | 28d. DESCRIB | E NOW INJURY O | CCURED | / |
| 3 Suicide 5 Could not be determined 28a. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) 28a. PLACE OF INJURY — At home, tarm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | Route Number, |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and menner as stated. | | | | | | | | | a) and menner as stated. |
| SE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | Dan-Days | | | 29c. LICENSE NU | | | | (Month, Day, Year) |
| 0 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DEATM | (ITEM 27) (Type Prin | t) - | 240 | 480 | | eb. | 9, 1996 |
| | FERNANDO U | 1. Ferre | NID | 5 | 810 alto | NO | 2120 | 6 | |
| | FEB 1 3 1996 | 32 pagistrans unatu | Me. | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | State of Maryland / Depa | rtment of | | d Mental H | /giena 9 | 6 | 3624 | | | |
|-----------|--|----------------|--|-------------------------------------|--|---------------------------------------|--------------------|--|---|--|--|--|
| | | | 1. Decedent's Name (First, Middle, Last) | | | 2. Date of D | | | 3. Time of Death | | | |
| | Physic | | Eva D. Zephir | | | Febru | pary 9, | 1996 | 205 AM | | | |
| 3 | /Medi Examir | | 4e. Fecility Name (If not Institution, give street and number) | | 4b. City, Town | , or Location of Dea | | of Deeth | | | | |
| | | | 1235 Hillside Road | | Pasad | ena | A.A | .Co. | | | | |
| | Funeral | | 1235 Hillside Road 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) | If Under 1 Ye Months Dey | | Hrs. 8. Dete of B | | process of the same of the sam | olece (State or Foreign | | | |
| | Director | | 217-09-9232 | | | Nov.4 | | | laryland | | | |
| | and ** | | Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Loc | ation | | | | | 10d. Inside City Limits | | | |
| | Maryl f sho | ō | | adena | | | | | 1 ☐ Yes 2 ☒ No | | | |
| | the 288 | Directo | 10e. Street end Number | 10f. Zlp Code | 9 | | 10g. Citizen of | What Cou | nto/? | | | |
| | 3ª or | | 1235 Hillside Road | | 1122 | | | S.A. | , | | | |
| | hours after death with the Maryland turat', or items 23s or 28s-f show | Funeral | | | | ? (Specify Yes or Nuerto Ricen, etc.) | o- 14. Red | e - Ameri | can Indian, | | | |
| 0 | or the | | 1 Never Married 2 Nerried 1 Yes 2√2 No | _ | | uerto Ricen, etc.) | | ck, White, | | | | |
| 5-0020 | ours | l by | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | □Yes 2√2N | lo Specify: | | Specif | v: Whi | .te | | | |
| 5 | be filed within 72 hours after death with the Marylar tial hygiene. d other than "natural", or items 23s or 28s-f showevert, the Medical Example must be notified at | Completed | 15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give I | ent's Usual Occ kind of work dor | cupation ne during most of ired) | working | 16b. Kind of B | usiness/In | dustry | | | |
| 2121 | vithin ne. han | idm | Elementary/Secondary (U-12) College (1-4or 5+) | | ired) | | ~ | | | | | |
| | filed within 72 Hygiene. Ither than "nat ant, the Med c | ပိ | 17. Father's Neme (First, Middle, Last) | usewife | 18 Mother's | Name (First, Middle | Own | | | | | |
| Maryland | | 9 Be | George Rebstock | | | ry Curri | / | 110) | | | | |
| 2 | d 2 should th and Men 7 Is marks traumatic | L C | | n Address (Stre | | r Rural Route Num | | State Zir | Code) | | | |
| _ | d 2 d 2 d 4 d 4 d 4 d 4 d 4 d 4 d 4 d 4 | | | | de Road | | ooi, ony or rown, | , 0,010, 2.1 | 7 (330) | | | |
| altimore, | - I 5 5 | | 20e. Method of Disposition 20b. Place of Disposition cemelery, crem | ition (Name of | | Date | 20c. Location | - City or To | own, State | | | |
| E | Pages nent of int: If its iry or o | | 1 XBuriei 2 Deremation 3 Diemoval from State | | | b.12,199 | Dol+i | maxa | Ma | | | |
| alti | 교환경공 . | | COGGE III | Name and Add | | M. 12, 199 | Daici | more, | , MG • | | | |
| m | Depa Impo any I | | Many Many h M | cCully | Funeral | Home | | | | | | |
| | | | 23a. Párt1. Enter the diseese, or complications the ceused the death. Do not enter shock, or heart teilure. List only one cause on each line. | 204 MOH | ntain Ro | ad Pasad | ena, Md. | 21122 | Approximate | | | |
| | Physician | 0.0 | snock, or neer tellure. List only one cause on each line. | | | | | | Intervel Between Onset end Death | | | |
| r | /Medical | | Immediate Cause (Final disease or condition | Calato | w In | · luso | | - 3 | Me wints | | | |
| | Examiner | | resulting in death) a. Due to (or as a consequence) | uence of): | 1 000 | · · · · · · | | - | 117 | | | |
| | D # | iner | - Emblinema | FAI | N LUB | ILOR | | | 16 worth | | | |
| | be executed sician and burial-transit | Examiner | Sequentially list conditions, | uence ot): | | | | | | | | |
| 760, | cian a | | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | | | | | | | | |
| 289 | 0 2 0 | dical | that initiated events resulting in deeth) Last Due to (or es e consequ | ience ot): | | | | | | | | |
| | ding | /Me | d | | | | | | | | | |
| Box | leath certifica attending pl | cian | | | | | | | | | | |
| o. | y the | Physician/Med | Pert II. Other significant conditions contributing to death but not resulting in the un | derlying ceuse | given In Part I. | | | | o the cause of death? | | | |
| J. | that ned b | by Pi | ating fluillitin | mer | willen | 1 | Yes 2□ No | 3 440 | bably 4 Unknown | | | |
| Hecords, | requires that been signed b should be deta | | P. O. V & D O. | 1 1- | 1 .) 0 | 24a. Wa | s an autopsy | 24b. W | ere autopsy tindings | | | |
| ပ္ပ | law recias bee | olete | wany afra | Uytu | 1-12 | pen | ormed? | CO | railable prior to empletion of ceuse death? | | | |
| | sician: The law certificate has t irector, page 2 s | Completed | Colmun Chter Reine | | | 1 | Yes 2 DNo | | Yes 20 No | | | |
| Vital | iffical tor, p | 0 | 25. Was cese reterred to medical | | 26 Place of | Death (Check only | | | 3103 243110 | | | |
| | Physician: this certific ral director, | 0 8 | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient | 3□ DOA | Wher: | ng Home 5 Thes | | er (Speci | (v) | | | |
| 101 | g Phys er this neral di | ı. | 27. Manner of Death 28a. Date of Injury 28b. Time of | 28c. In | | | how injury occur | | ,, | | | |
| 0 | Attending In death. | atio | 1 ☐Natural 5 ☐ Pending (Month, Dey Year) Injury 2 ☐ Accident Investigation | | ☐ Yes 2 ☐ No | | | | | | | |
| INISION | er de recto | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Placa of injury - At home, farm, stre building, etc. (Specify) | et, factory, offic | Ce C | | (Street and Numi | ber or Run | al Route Number, | | | |
| 5/ | rs afte al Dir led in | | oning, our town, outer | | | | | | | | | |
| 1 | Hospital or Attend 24 figurs after deatl Puneral Director: etely filled in by the | edicai | 29e. Certifier (Check only (Ch | occurred at the | time, date and p | lace, and due to the | cause(s) and made. | anner as s | tated. | | | |
| | 0 0 | Med | one) end manner stated. | | nse number | | | | | | | |
| | Vithia To the | | 29b. Signeture end title of certifier | | 21703 | | 29d. Date signe | 01 | O / | | | |
| | | | 1 . h. mand & almost 1 . All | | 11/-0 | | 02/0 | 1 | 16 | | | |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, F | | SMALL | wonn | pn h | ACA | DENA MO | | | |
| | -0 | 40 | MICHAEL GARAM MD 8651 31. Date tiled (Morith, Day, Yeer) 32. Registrar's Signature | / / | - , , , , , ~ . | | NO 0 | 11071L | 3/102 | | | |
| | Sta Registr | 300 | FEB 1 3 1996 Fali | | | | | | | | | |
| DHI | MH 16 Rev 6/9 | | THE THE STATE OF T | | | | | | | | | |
| | | | | | | | | | | | | |



Amended #6, #7, P.H., Cecil County 1/26/96

| | | FOR | |
|---|---|-----------|--|
| 1 | _ | STATE | |
| | | REGISTRAR | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - REGISTRAR | | CERTII | FICATE OF | DEATH | | REG. NO | | | | | | | |
|--|--|-------------------------------------|--|---|----------------------|--------------------------------|-------------|-------------------------------------|--|--|--|--|--|
| t. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE | OF DEATH | w | YEAR | 3. TIME OF DEATN | | | | |
| | Bertha | Mae Al | len | | January 22, | | | | 1559 | | | | |
| 4. SOCIAL SECURITY NUMBER 222-03-6814 | | E (In yrs. last birthday 3 82 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE ((Month) | 30;=1 | 912 | 8. BIRTH Count | IRTNPLACE (State or Foreign ountry) Maryland | | | | |
| 90. FACILITY NAME (W not Institution, give st 1063 Singerly R | | | 96. CITY, TOWN | n LOCATION OF DE | ATN | | | cil | NTY OF DEATN | | | | |
| 100. STATE 10b. COUNTY Maryland Cec | | | , TOWN OR LOCATION 10d. INSIDE | | | | | | | | | | |
| 10s. STREET AND NUMBER | | | 101. ZIP CODE 10g. CITIZEN OF WI | | | | | | t YES 2 X NO | | | | |
| 1063 Singerly Road 21921 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yee or No. — 14. RACE — | | | | | | | | | | | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 X Wildowed 4 Divorced | FORCES? 1 YE IF YES, GIVE WAR OR | S 2 ANO | If yea, sp | 13. WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 X NO Specify: Whit | | | | | | | | | |
| 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | (Give kind o | Se. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refred.) Homemaker 16b. KIND OF BUSINESS/INDUSTRY n/a | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William | Walters | | | 18. MOTNER'S NA | | Middle, Maiden | | | r | | | | |
| 190. INFORMANT'S NAME (Type/Print) Harold H. Hende | rson | | Normira | | Route Numb | oer, City or Tow | n, State, 2 | (ip Code) | | | | | |
| 20. METNOD OF DISPOSITION 14. Burlal 2 Cremation 3 Rem | 2 | 0b. PLACE AND DAT | E OF DISPOSITION (N | ame of 1-2 | 6-96n | E 20c. LC | _ | 21921 - City or Ti | own, State | | | | |
| 4 Densition 5 Other (Specify) St. Paul's Methodist Cemetery Johnstown, Ma | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 122. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521 | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Dissesse or injury that initiated events resulting in death) LAST e. Cause Madradad Marked Ma | | | | | | | | | | | | | |
| PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WOLCERTAIN | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL | | | EATH (Check only one | , | | | | | | | | | |
| EXAMINER? | HOSPITAL: | | | Nursing Home 5 Sesidence 6 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJUF (Month, Day, Yes | r) | M 1 | F 28c. INJURY AT WORK? M 1 YES 2 NO | | 28d. DEŞCRIBE NOW INJURY OCCUR | | | IED | | | | |
| 3 Suicide 6 Could not be 4 Nomicide determined | 28s. PLACE OF INJU- building, atc. (S | IRY — At home, tem specify) | s, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) | | | | | | Route Number, | | | | |
| 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. | | | | | | | | | | | | | |
| 29b, SIGNATURE AND TITLE OF CERTIFIE | R | | | 29c. LICENSE NU | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| Comit Leur | | | | 019043 123196 | | | | | 3196 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KENNETH LEWIS MO IL PERMINICION ST. MIDDLETQUIN DE 19709 31. DATE FILED (Month Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FINEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal:

IMPORTANT: If Hem 28 is marked, or Hem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are I calble

State of Maryland / Department of Health and Mental Hygiene 96 03626

| | | | | | | Ce | rtificate | e of | Death | | | Reg. No. | 20 | 00020 | |
|---------------------|--|----------------|--|---|--|-------------------------------|---|-------------------|--------------|---------------------------|---|---------------------|--------------------------------|--|--|
| П | D 1 | | Decedent's Name (First, Middle, | Last) | | | | | | | 2. Dete of De | | V | 3. Time of Death | |
| Physic /Medi | | | Alice King | | | Anderson | | | | Month January | v 26 19 | Year | 5:03A | | |
| | Exami | | 4a. Fecility Nema (If not institution, | | um <i>ber)</i> | | | | 4b. City, To | wn, or Lo | cation of Death | | | 3.03A | |
| 1 | LAMITIN | ,,, | South River Con | v. & Reb | ah Cent | or | | | Edgev | rator | | Ann | O A2011 | ndol | |
| Н | Euparal | _ | | S. Sax | 7. Aga (In yrs. | | If Under | 1 Yeer | | | | | e Aru | | |
| į. | Funeral Director | | 215-50-0662 | 1□M 2007F | | Yrs. | Months | Days | Hours | Min. | 8. Data of Birt (Month, Da | | | plece (Stata or Foreign ntry) | |
| | | | Usual Rasidance of Decedant | | | | | | | | July 12 | 1907 | Maryland | | |
| | /lan | | 10a. Stata 10b. County | | 10c. Cit | y, Town or L | ocation | | | | | | | 10d. Insida City Limits | |
| | Man | ō | MD Anne Ar | d a 1 | | 77.1 | | | | | | | | 1 □ Yes Q No | |
| | the post | Director | MD Anne Ar | under | | Edgew | 10f. Zlp | Coda | | | | 10g. Citizan of | What Cou | | |
| | be filed within 72 hours after death with the Maryland ntal Hygiene. Id other than "naturat", or itams 23s or 28s-f show event, the Medical Examiner must be notified at | | 144 Washington | n 1 | | | 1 | | | | | | | | |
| | a 22 | Funeral | 11. Maritai Status | | edant Ever in U. | C 12 | Wee Door | | 1037 | inin? (Co. | alfe Van ar Na | Unite | | tes | |
| | Han Han | 5 | | Armed F | orcas? | | if Yas, spec | ify Cub | en, Mexical | n, Puarto | ecify Yes or No Rican, atc.) | Bla | ick, White, | | |
| 20 | s ag | by F | 1 ☐ Never Merried 2 ☐ Merried XX Widowed 4 ☐ Divorced | If Yes, G | NAXX.W | | 1 ☐ Yas 2 ☑ No Specify: | | | | | Specia | fy: | | |
| 8 | lural lural | B | | Yaar or I | Jates: | 40. 5 | | | | | 1 | | | hite | |
| Ŋ | na na | Completed | 15. Decedant's (Specify only highast) | grade completed, |) | (Giva | 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) | | | | | | 16b. Kind of Business/Industry | | |
| 12 | e filed within al Hygiene. I other than "I went, the Med | B | Elamantary/Secondery (0-12) | Collega | (1-4or 5+) | ıııa. | DO NOT US | a retire | | 1 | | Charles | | | |
| 7 | Horaic H | | 12 17. Fathar's Nama (First, Middia, La | | | | _ | | Cle | | (Final Middle | State (| | nment | |
| an an | d la b | Be | | | | | | | 18. Moth | | | Maidan Sumai | me) | | |
| ž | should be filed v nd Mental Hygie i marked other t umatic event, th | 2 | Francis S. King | | | | | | | Mar | ie Shaw | 7 | | | |
| Maryland 21215-0020 | 2 sho | | 19a. Informant's Name/Ralationship | p (Type, Print) | | | - | | | | | er, City or Town | | | |
| | is 1 and 2 should of Health and Men Harn 27 Is marke other traumatic | | Sarah A. King | | | 1 | | | et Ne | w Ca | rrollto | n, Mary | land | 20784 | |
| Ore | of H of H | | 20a. Mathod of Disposition 1 ☐ Burial 2 XCremation 3 | □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ | | lace of Dispo ematary, cre | osition (Name of the contract | na of thar pla | ce) | | Data | 20c. Location | - City or To | own, Stata | |
| altimore, | permit. Pages Department of I Important: If its any injury or or | | 4 □ Donetion 5 □ Other (Spe | | | Linc | olin C | roms | tory | 1/2 | 7/96 | Bront | hoor | Maryland | |
| a | Departr Meportu any Inja | | 21. Signature of Furtaint Sarvice Lic | censee | | 2 | 2. Nama an | d Addre | ss of Facili | Yohn | M Tax | lor Fun | orol | Home, Inc. | |
| m | SOESO | | 1 Wallance | 7 | | 1 | 47 Du | ko d | of Gla | MCOC | tor St | Annan | olic | MD 21401 | |
| | _ | | 23a, Part 1, Enter tha disaasa, or co | omplications that | caused the deat | | | | | | | | 0113, | Approximeta | |
| | Physician | | 23a. Part1. Enter tha disaasa, or co shock, or haart fallure. List on | nly ona causa on | each lina. | | | | | | | | | Intarval Between Onset and Death | |
| ţ | /Medical | | tmmediata Ceuse (Final | D | | | 1 | | ase | | | | | 10 | |
| | Examiner | | disease or condition rasulting in death) | 0. | arkn | son | Ul | se | ase | | | | | 10 years | |
| l, | | ē | | | Dua to (o | r as a conse | quance of): | | | | | | | , | |
| | nsit | Examiner | | b | | | | | | | | | | | |
| - 10 | al-tra | Xa | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying | | Due to (o | r as e conse | quance of): | | | | | | i | | |
| 68760, | be e | le: | causa. Entar Undarlying Cause (Disaasa or injury C. | | | | | | | | | | | | |
| 387 | ertificate be executed ling physician and se as the burial-transit | edical | that initiated evants resulting In death) Last Due to (or es e consequence of): | | | | | | | | | 1 | | | |
| × | eath certificate be executed attending physician and for use as the burial-transit | ₹ | | d | | | | | | | | | ! | | |
| Box | that the death cer ed by the attendir detached for use | Physician | | | | | | | | | | | | | |
| P.0. | 0 0 2 | ysi | Part II. Other eignificant conditions | contributing to d | leath but not resu | ulting in tha u | ndarlying ca | ausa giv | en in Pert I | 1. | 23b. Dtd 1 | lobacco use co | ontribute t | o the cause of death? | |
| ď | hat the | | | | | | | | | 1 ☐ Yee 2 No 3 ☐ Probably | | | bebly 4 Unknown | | |
| Records, | 8 58 | l by | | | | | | | | | 1500 | | T | | |
| 0 | v require been si should | ec | | *************************************** | | | | | | | 24a. Wes perfo | an eutopsy rmed? | av | ere eutopsy findings allable prior to | |
| ec | 2 S S | Be Completed | | | | | | | | | | | of | mpletion of cause death? | |
| X | The law ate has t page 2 s | | | Total Control of the | | | | | | | 101 | ras 250 No | 11 | □Yas 2□No | |
| Ta | ysician: The lass certificate hadirector, page | | 25. Was casa rafarred to medical | | | | | | 26. Place | of Death | (Check only o | na) | | | |
| > | Physician: r this certific and director, | To | axaminar? 1 □ Yas ¾[XNo | Hospital: 1 | tnpatiant 2 | ER/Outpatie | nt 3 DO | A Oth | er: 4XXV | ursing Hor | ma 5□ Rasio | dance 6 🗆 Oti | her (Specil | (v) | |
| Division of Vital | g Phys er this seral d | | 27. Mannar of Death | 28a. Deta | of Injury oth, Day Year) | 28b. Tima o | f 2 | Bc. Injur Wor | | | | now injury occu | | | |
| Ö | Attanding is death. actor: After by the funer | atlo | Naturel 5 Panding 2 Accidant invastigat | | nii, Day real) | Injury | м | | Yes 2□ | No | | | | | |
| N S | Atta or de octo by th | Ific | 3 Suicide 6 Could not datarmine | be 28a. Place | e of Injury - At ho ling, atc. (Specify | ma, farm, st | raat, factory | , office | | 1 | 28f. Location (Street and Number or Rural Routa Number, | | | | |
| ā | a after a d in in in in in in in in in in in in in | Certification: | 4 D Hornicide | Duild | ing, atc. (Specif) | ") | | | | | City or Tov | vn, Stara) | | | |
| | nera nera y fille | - 1 | 29a. Certifying F | Phyelcian: To the | a best of my know | wledga, daat | h occurred a | at tha tir | na, date en | d plece, e | and dua to tha | causa(s) and m | enner as a | tated. | |
| | P Fu | edical | (Check only one) 2 Medicat Expone) | aminer: On the b | easis of examinat oner steted. | ion and/or in | vastigation, | in my o | plnion, daa | th occurr | ed at tha tima, | date and place, | and dua t | o tha cause(s) | |
| | To the Hospital or Attanding Phwitin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | Me | 29b. Signatura and titla of certifier | | . / | | 29c | Licens | a number | | | 29d. Data signe | ed (Month, | Day, Year) | |
| | - > - 0 | | (9) | 11/1 | 1/ | | 7 | 10 | 50 | 75 | 2 | Tanan | . 20 | 1006 | |
| | | | 20 Name and address of | V V / | MU | 020\ 7 | Deint | |)) | ~ (| | Januar | y 20, | 1330 | |
| | | | 30. Nama and address of person wh | complated cau | sa or daath (Itam | ∠3a) (Type, | 7 A(12 | 14 | 1. | 101 | Inc. A | 1410 - 00 | 100 | MD21401 | |
| | | | 31. Data filed (Month, Day, Year) | 33 5 | PACIETY Sinner | VI), | 2003 |) 14/ | ecrea | | KWY, M | nnapo | 113/ | 1111/21-101 | |
| | Sta Registr | | JAN 30 19 | 36 | Registrar's Signa | Partall | 1 | | | | , | • | | | |
| | riegisti | en . | JAN OU 13 | JU ji | A C TO A COLUMN TO THE | | | | | | | | | | |

| HE HOSPITAL OR ALTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after det HE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the fi ewithin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ORTANT: If Nem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical ex | ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | P. P. | m 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|-------|---|
|--|--|-------|---|

| amended # 16b, | 1/05/94 STATE OF MARY | D. S.S. al | LEGATOR H | Co, | MENTAL HYCI | ENE | 96 | 03621 |
|--|--|--|-----------------------------|---|--|--------------------------------------|------------|---|
| REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | CERTIF | ICATE OF | DEATH | REG. | NO. | YEAR | 3. TIME OF DEATH |
| ANNA MAE AL | SIP | | | | JÄNÜARY | 24 199 | 6 | 1:15 PM M |
| 4. SOCIAL SECURITY NUMBER 220-10-4567 | 1 M 2 X F | GE (In yrs. last birthday) 90 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 1905 | Count | HPLACE (State or Foreign MARYLAND |
| 5 CUMBERLAND ARMS A | | | CUMBER | RLAND | EATH | 9c. COU | LEGA | |
| CUMBERLAND ARMS A RESIDENCE OF DECEDENT 10e. STATE MARYLAND ALL | EGANY | | Y, TOWN OR LOCAT | | 158 | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| | | | 101 | ZIP CODE | | 10g. CIT | ZEN OF | WHAT COUNTRY? |
| 10 NORTH LIBERTY | STREET | | | 21502 | | | U.S. | . A . |
| 10e. STREET AND NUMBER 10 NORTH LIBERTY 11. MARITAL STATUS 1 Never Merried 2 Merried 3XXWidowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O | ES 2 X NO | 13. WAS DEC | ENDENT DF HISPAI ecity Cuben, Mexico 2 X NO Specifi | NIC ORIGIN? (Specifien, Puerto Rican, etc. y: | y Yes or No— | Blac | E — American Indian, ck, White, atc. |
| 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 1 0 17. FATHER'S NAME (First, Middle, Last) | | 18e. DECEDENT'S (Give kind of We. Do NOT u | , | st of working | | Cafete | ria | / COOK |
| 17. FATHER'S NAME (First, Middle, Last) | | ALLEGAN | . CO. DOZ | | ME (First, Middle, Me | , , , , , , | TIN | 7 COOK |
| RALPH WALTON | | 19b MAII INC | ADDRESS (Street | ANNA | | | Corle | |
| EARL ROYCE | | | | | AND MARYI | | 1502 | 2 |
| 20e. METHOD OF DISPOSITION 1 Neurist 2 Cremetion 3 Remediate Proceedings of the Communication and Com | POSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Monte 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | | | MERRI' | ND ADDRESS OF FA | FUNERAL TREET CUM | HOME | | |
| shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | C.O.P.D. DUE TO (DR / | AS A CONSEDUENCE OF A STHMATIC AS A CONSEDUENCE OF AS A CONSEDUENCE OF AS A CONSEQUENCE BRONCHI' | ris dise. | ASE | | | onact and Death 60 Years 60 Years |
| | d | N. S. A M M. | | | e - 1 | | | |
| PART II. Other algnificent condition MILD HYPERTEN DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES: 2 NO 27. MANNER OF DEATH XX Mature 1 5 Panding | | in but not resulting | in the undersyin | g cause given in | PE | S AN AUTOPSY REDRIMED? ES 2 NO | 24 | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 ND |
| DID TOBACCO USE CONTI | RIBUTE TO CAUSE | | ES NO X | | Ν□ | | | |
| EXAMINER? | HOSPITAL: | | OTHER: | | C. et Milliana | | | |
| 1 X YES 2 NO | 1 Inpatient 2 ER/ | | | IURY AT | 6 Other (Specify | | CUBED | |
| | (Month, Day, Ye | | JURY W | YES 2 ND | 284. DESCRIBE II | OW INSONT OC | CONED | |
| a Cartette | 28e. PLACE OF INJ building, atc. (| URY — At home, term, (Specify) | street, factory, offic | • | 281. LOCATION (S City or Town, | | r or Rural | Route Number, |
| CONBUN DINY | ICIAN: To the best of my k | | | | | | | (s) and manner se stated. |
| III 296 SIGNASTIRE AND TITLE OF CONTINE | R / | | | 29c. LICENSE NU | IMBER | 29d, DA | TE SIGNE | ED (Month, Day, Year) |
| | 4 | | | D 0915 | | | | RY 24 1996 |
| DR PAUL SNOW | O COMPLETED CAUSE OF | | | | UMBERLAN | | | |
| 31. DATE FILED (Month, Day, Meet) 31. DATE FILED (Month, Day, Meet) | PERFORMANTS | SIGNATURE LAND | | | | | | |

1.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | TATE OF MAR | | PARTMENT TIFICATI | | | MENTAL HYGIEN | E | |
|--|------------------------------|----------------------------------|---------------------------------------|-------------|----------------------|---|----------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | 0211 | | 2 | DEATH | 2. DATE OF OEATH | | 3. TIME OF DEATH |
| Melvin Donald | | | | 411 | en | Januares & | 35 1996 | 1020 H |
| 4. SOCIAL SECURITY NUMBER 5. | SEX 8. A | GE (In yrs. last birt | thday) IF UNDER | 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign |
| 160-26-2876 | X M 2 □ F | 63 | YRS. MONTHS | DAYS | HOURS MIN. | (Month, Dey, Year) 06-10-32 | NJ | |
| 9e. FACILITY NAME (If not institution, give street | and number) | | 9b. CITY | , TOWN C | OR LOCATION OF D | | 9c, COUNTY OF | |
| PENINSULA REGIONAL | L MEDICAL | CENTER | | SAL | ISBURY | | WICOMI | CO |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10 | c. CITY, TOWN | OR LOCAT | TION | | | 10d. INSIDE CITY |
| MD Somer | set | | Princes | | | | | LIMITS? |
| 100. STREET AND NUMBER | | | | 101 | . ZIP CODE | | | WHAT COUNTRY? |
| 13828 F. Cornish | | | | | 21853 | | USA | |
| 11. MARITAL STATUS 12. 1 Never Married 2 X Married | WAS DECEDENT EVE | | | | | NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) | Bia | CE — American Indian, ck, White, atc. |
| 3 Wildowed 4 Divorced | Korean (| R DATES | - 1 | | 2 NO Specif | | Spe | Black |
| 15. OECEDENT'S EDUCATION | ON | | ENT'S USUAL O | CCUPATIO | ON . | 16h KIND OF BUS | I SINESS/INDUSTRY | Diack |
| (Specify only highest grade com | pleted) plege (1-4 or 5+) | (Give k | ind of work done NOT use retired.) | during mo | st of working | TOU. KIND OF BOX | 314L33/14DQ3141 | |
| 12 | onege (I-4 or 5 +) | Merc | hant Ma | arin | e Seaman | Mercha | nt Marin | es |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (First, Middle, Meiden | Sumeme) | |
| Unknown | | | | | Eva Mi | lls Parker | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City or Town | n, State, Zip Code) | |
| Viola Allen | | Ρ. | O. Box | 116 | Eden, | MD 21822 | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 X Cremetion 3 Removal | from State | 20b. PLACE AND cemetery, cremate | | | ame of | | CATION - City or | |
| 4 Donation 5 Other (Specify) | EE. | Capita. | l Crema | | | | Dover, l | DE 19901 |
| 100 SI B. | | | | | | Funeral Ho | | |
| XDM A. JM | rce | | 8 | 19 4 | th Stree | et Pocomok | ce, MD | |
| 23. PART Enter the diseases, or com ahock, or heart fallure. List | plicatione that ceu | used the death on each line. | . Do not enter | the mo | de of dylng, suc | ch ss csrdlec or reapi | ratory arrest, | Approximata Interval Between |
| IMMEDIATE CAUSE (Finel | | | | | | | | Onset and Death |
| disease or condition reaulting in death) | 70 | plu | em | - | | | | 4 day |
| | DUE TO (ON | A CONSEQUE | NCE OF): | | Magazini (| a | 110- | 4 Days |
| Sequentially list conditions, b. | DUE TO (OR | AS A CONSEQUE | NCE OF: | m | a -, | Tham | Nigh | Cicio |
| If any, leading to immediate cause. Enter UNDERLYING | | | Ce | 00 | | | 0 | |
| CAUSE (Disesse or Injury that initiated events | DUE TO (OR | AS A CONSEQUE | NCE OF): | | | | | |
| resulting in death) LAST | | | | | | | | |
| PART II. Other algnificent conditions of | ontributing to dear | th but not resu | ilting in the u | nderivin | g cause given in | Part I. 24a. WAS AN | AUTOPSV 24 | IL WERE AUTOPSY FINDINGS |
| Gickle cel | ler. | iles 1 | Luca | u | a C | PERFOR | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Tialeter-1 | 1000:7 | TI A R | Dave l | 7 7 | 2 -0 | 1 VES 2 | X NO | OF DEATH? |
| DID TOBACCO USE CONTRIB | LITE TO CALISI | E OF DEATH | YES 🗆 | NO F | UNCERTAL | N | | 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | OIL TO CAOO! | | F DEATH (Check | | | 17 10 1 | | |
| | OSPUAL: | Outpatiant 3 🗆 | DOA 4 Nu | | ne 5 🗆 Residence | 8 Other (Specify) | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJU | JRY 2 | Bb. TIME OF | 28c. IN. | JURY AT | 28d. DESCRIBE HOW I | NJURY OCCURED | |
| 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Ye | per) | INJURY M | | ORK? YES 2 NO | | | |
| 3 Suicida 8 Could not be | 28a. PLACE OF IN. | JURY — At home, (Specify) | farm, street, fac | tory, offic | 28 | 281. LOCATION (Street a City or Town, State) | and Number or Flura | l Route Number, |
| 4 Homicide detarmined | | | | | | | | |
| | N: To the best of my i | cnowledge, death | occurred at the | fime, deta | and place, and du | e to the cause(s) and made | nner as stated. | |
| one) 2 MEDICAL EXAMINER: 0 | on the beals of exemin | nation and/or inve | etigetion, in my | opinion, o | death occured at the | time, deta and place, an | d dua to the cause | (a) and manner as stated. |
| 286. SUMATHIE AND TITLE OF CERTIFIER | 1/- | | | | 29c. LICENSE NU | MBER | 29d. DATE SIGNE | D (Month, Day, Year) |
| - maring | re | This | | | 11570 | 070 | 1/3 | 5/96 |
| 38. HAM AND ADDRESS OF PERSON WHO CO | OMPLETED CAUSE OF | P DEATH OTEM 2 | T) (Type, Print) | 25 | liste | e Ble | iff 1 | RRZY |
| 31. DATE FILED (Mornth, Day, Year) JAN 2 9 1996 | Tille de | SIGNATURE REAL | dall | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

| and Mental Hygiene | repartment of riealth and |
|--------------------|---------------------------|
| h Ban No | Certificate of Death |
| h Reg No. | Certificate of Death |

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| | 0 | U | U | U | 4 | |

| Physician | | Helen | 7 | v Virgini | - | ANDEI | COM | | | | | Month | Day | | Yaar | 3. Time of Death |
|--|---|--|---|---------------|--|--|-----------------|------------|---------------------|---|------------|---|--------------|-------------------|------------|--|
| /Medica Examine | | 4a. Facility Nama (If not instituti | on, giva | street and nu | mber) | ANDE | KDON | | | 4b. City, Town | | January cation of Death | | | of Death | 2:30 am |
| Examinio | . | Franklin Squa | are | Hospit | al | | | | | Ros | ssvi | lle | | n . 1 . | | |
| Funeral | | 5. Social Security Number | 6. Se | ex | | yrs. last bir | | f Undar 1 | | If Undar 24 | | 8. Data of Birth (Month, Day |) Vana) | sali | 9. Birth | Te bleca (Stata or Foreig stry) |
| Director | | 579-48-8215 | 1(| □M 21XIF | 92 | | Yrs. | fonths | Days | Hours | | Mar. 24 | 1. 19 | 03 | Wash | ington D. |
| | | Usual Rasidance of Dacedant | | | 1.0 | | | | | | | | | | | |
| show at all | | 10a. Stata 10b. Count | У | | 100 | . City, Tow | n or Locat | ion | | | | | | | 1 | Od. Inside City Limit |
| 10a. Sta 10a | | | Harf | ord | | | | | | Joppa | 3 | | | | | 1 ☐ Yas 2 💢 N |
| or 2 | 5 | 10e. Street and Number | | | | | | 10f. Zip (| oda | | | | log. Citize | n of W | hat Cour | ntry? |
| 23. | 20 | 1503 Bulls Lar | ne | | | | | | | 21085 | | | | U | SA | |
| or he | 11. Marital Status 1 □ Navar Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce | | 12. Was Decedant Evar In U, Armed Forcas? 1 ☐ Yas ②☑ No If Yas, Giva Yaar or Datas: | | | n U.S. 13. Was Dacedant of Hispanic Origin? (Si If Yas, specify Cuban, Maxican, Puerto | | | n? (Spe Puarto f | ecify Yas or No- Rican, atc.) 14. Race - A Black, W Specify: | | , Whita, | | | | |
| netural", edical Ex | 2 | 15. Deceda | nt's Edu | ucation | | 16a. | Decedan | t's Usual | Occup | ation | | | 16b. Kind | of Bus | | |
| Elan Elan | (Specify only high Elamantary/Secondary (0-12) | 1 | Collega (1-4or 5+) | | | (Giva kind of work dona during most of work lifa. DO NOT usa ratired) Clerk | | | of workin | ng |] | Pub. | Publication | | | |
| d other | 0 | 17. Fathar's Nama (First, Middle | , Last) | | | | | | | 18. Mothar's | s Nama | (First, Middle, | Maidan Si | umama | 1) | |
| Mental I arked of attic eve | | R. Leeds | Mi | ller | | | | | | Flo | oren | nce Duri | cell | Mug | rude | er |
| end 2 sh eeith end n 27 ie m ver traum | | 19a. Informant's Name/Ralation Eugenia Wehr, r | | | | | | | | | | Route Numbe | | | | Code) |
| | 20a. Mathod of Disposition 1 ☑Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (| | | State | | y, cramate | ory or oth | ar plac | œ) etery | h./ | Data /1/96 | Jopp | | | own, Stata | |
| nysician Medical xaminer | | 23a. Part1. Enter the disaese, o shock, or haart feilura. Lis Immediata Causa (Final disaasa or condition rasulting in deeth) | | | irato | ry Fa: | ilure | e fro | of dylr | ng, such as ca | ardiac o | d, Abing raspiratory ari | est, | Md | | Approximata Interval Batween Onset and Death |
| in end riel-transit Examiner | | Comments to the state of the | • | b | Dűe | to (or as a d | consequar | | | | | | | | 1 | |
| cian en buriel-tr | E LAG | Sequentially list conditions, if any, leeding to immadiate causa. Entar Undarlyling Causa (Disaasa or Injury that initieted evants | J | C | Dua | to (or as a t | orisequer | ice orj. | | | | | | | | |
| e ettending physician end d for use es the buriel-transit ician/Medical Examin | | rasulting in daeth) Last | l | d | Due t | o (or as a c | onsaquen | ce of): | | | | | | | 1 | |
| the etten shed for u | yaicia | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | ribute to | the cause of deat | | |
| igned by the e | | | | | | | | | | | | 1) (Y | es 2□ | No : | 3 Pro | bably 4 ☐ Unkno |
| 2 should | | | | | | | | | _ | performed? available prid | | ara autopsy findings ailable prior to mpletion of causa daath? | | | | |
| cate he page . page | | | | | | | | | | | | 1 □ Y | as 2 | No | 10 | Yas 2□ No |
| director, pag | | 25. Was casa refarred to medical examinar? | | Hoonitel: 4.4 | | | | | Low | | f Daath | (Check only or | na) | | | |
| T di di | - | 1 ☐ Yas 2 No | | | | 2 ER/Ou | | 3□ DOA | - | 4 LI Nursi | - | na 5□ Rasid | | | | iv) |
| after death. Director: After this certific I in by the funeral director, entification: To Be | and a | Z I MOOIOBIN | igation | 28a. Date of | of Injury th, Day Yea | | ima of njury | M 28 | Nor | yat k? Yas 2 □ No | | 8d. Dascribe h | ow injury o |)ccurre | d | |
| after death. Director: After I in by the funer ertification | | 3 Suicide 6 Could 4 Homicida | not be nined | | 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) | | | | 2 | 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) | | | | | | |

Certification: To Be Completed

Medical

1 Decedent's Name (First Middle Lest)

| | | | | | 1 LI Yas | 2 NO | 1 ∐ Yas 2 | ZU No | |
|--|--|---|----------------------|--------------------------------------|-----------------------------------|-----------|-----------|-------|--|
| 25. Was casa refarred to medical | | | | 26. Placa of D | aath (Check only ona) | | | | |
| examinar? 1 Yas 2 No | Hospital: 1 Inpatiant 2 | ER/Outpatient | 3□ DOA | Othar: 4 Nursing | Homa 5 Rasidance | e 6 □Otha | (Specify) | | |
| 27. Manuar of Deeth 1 Naturai 5 Panding 2 Accidant 1 Augustigatio 3 Suicide 6 Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c | Injury at Work? 1 ☐ Yas 2 ☐ No | 28d. Dascribe how injury occurred | | | | |
| | | 28f. Location (Stree City or Town, S | t and Numbe tata) | r or Rural Routa N | lumber, | | | | |

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the causa(s) and manner stated.

29b. Signatura and title of certifier,

29c. Licansa number

29d. Data signed (Month, Day, Year)

RD 1907

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

Emdadul Haque MD. 9000 Franklin Square Drive Baltimore Maryland 21237 31. Data filed (Month, Day, Year)

State Registrar

FEB 1



To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

years for some of a minimum and a significant sector 100

permit. Pages 1, 2, 3 should

| DALIIMORE, MARTLAND 21215-0020 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Reath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|--|
| , L.O. BOA 60/0 | eath certificate be executed v | attending physician and comp rtal Hyglene prior to burial, c | y, or other traumatic evi |
| DISCOUNTED TO THE PROPERTY LOS BOY BOY BOY BOY BOY BOY BOY BOY BOY BOY | YSICIAN: The law requires that the de | is certificate has been signed by the a tith the State Dept. of Health and Men | ed, or item 23 shows any Injury |
| | TO THE HOSPITAL OR ATTENDING PHY | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fill be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marke |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH Sidney Crouch Ashbrook January 23, 1996 23:00 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 X M 2 | | 63 462-42-4213 YRS. Jan. 26, 1932 Texas So. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital 01nev Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4204 Elizabeth Street 20853 United States 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried 1 TYES 2 NO BY Specify: Specify: 3 Widowed 4 Divorced Korea White ETED 10e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Elementary/Secondary (9-12) College (1-4 or 5 +) COMPL Systems Analyst United States Government once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surneme) 76 Verda Guy Ashbrook BE Eunice Crouch notified 190. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bobbie J. Ashbrook 4204 Elizabeth Street, Rockville, Maryland 20853 8 20e. METHOD OF DISPOSITION
1 Burlet 2 X Cremetton 3 Rem
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) Jan. 26, 1996
Montgomery Crematorium, Inc. 20c. LOCATION --- City or Town, State DATE must Bethesda, Maryland examiner TO SIGNATURE OF FUNERAL SERVICE LICENSEE Robert A. Pumphrey 300 West Montgomery Rockville, Maryland Funeral Home/Rockville, Avenue 20850-2805 M00846 wh medical 23. PART I. Enter the diseases, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on sech line. Intarval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition VM and 23 shows any Injury, or other traumatic event, resulting in death) DUE TO OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 - YES -2 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN, PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) or item HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH marked, 28e. DATE OF INJURY 28c. INJURY AT WORK? 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED Watural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined COMPLETED 28 4 Homicide 29e. CERTIFIER DECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL ion end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner as stated 29b. SIGNATURE AND TITLE O CERTIF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

Prince

32 REGISTRAR'S SIGNATURE RANGELL

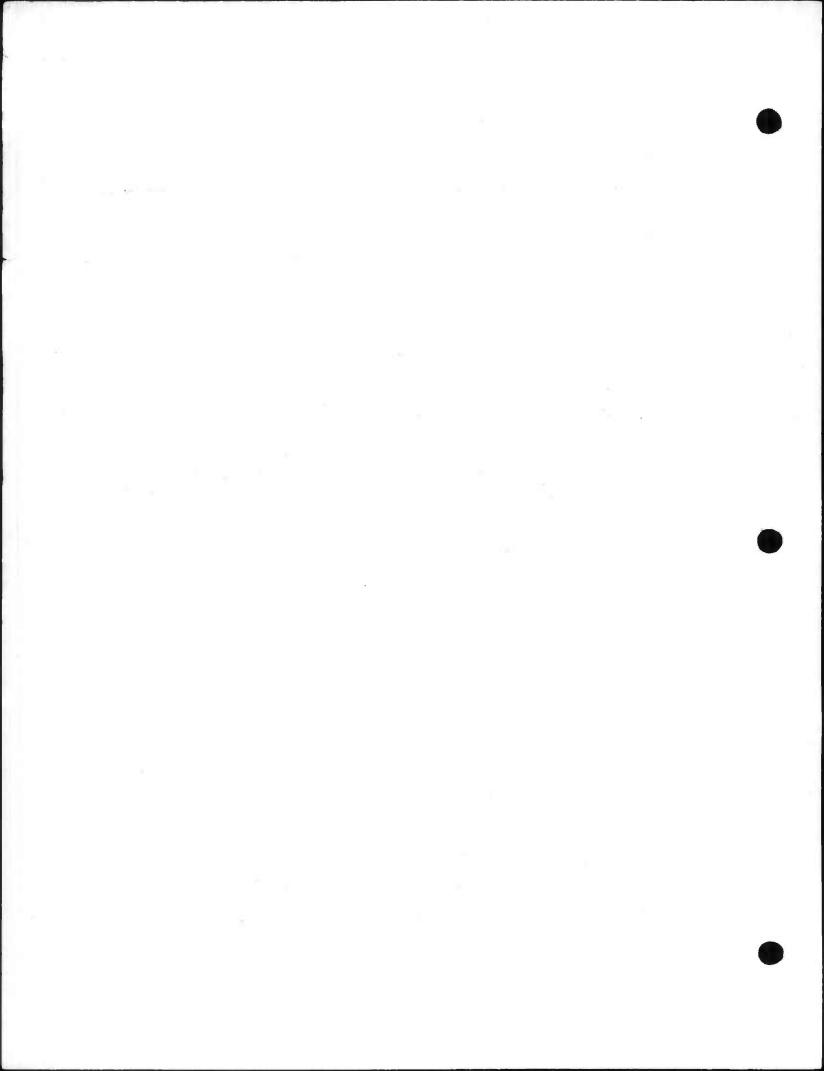


2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF

1996

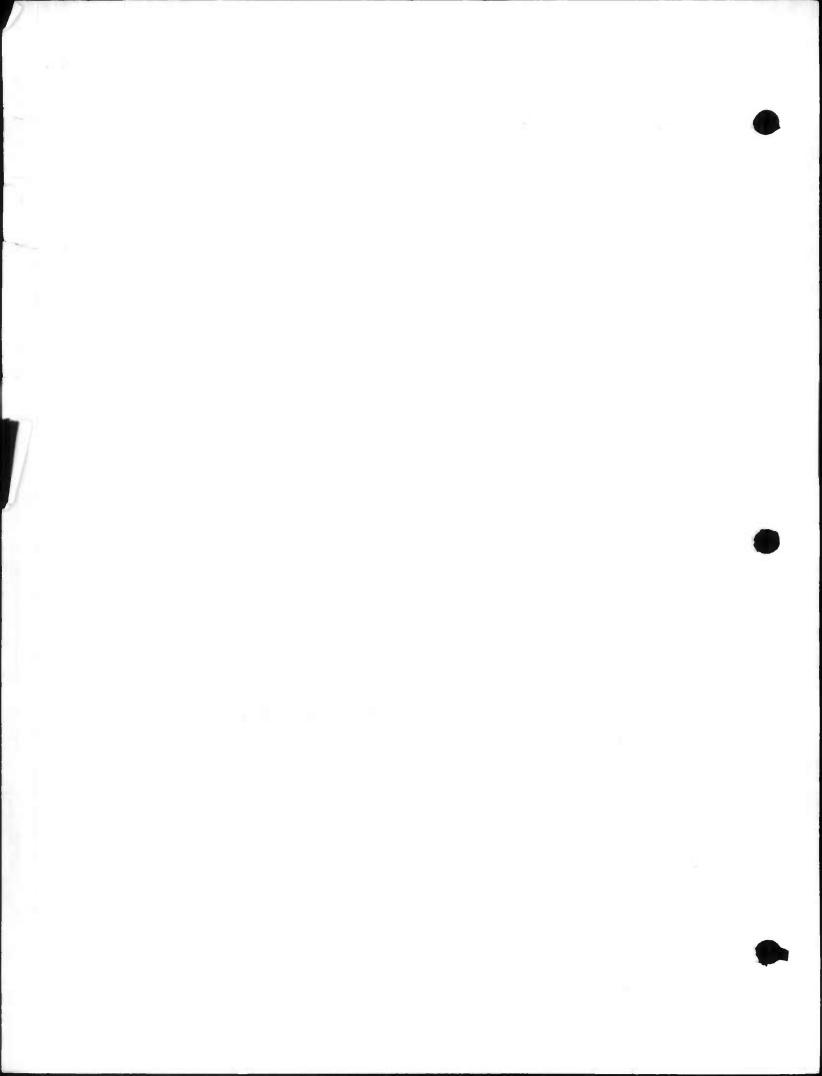
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| TO THE MINISTRA IN ATTENDING DAVICION. The Jam requires that the death neartificate he economist with thouse deep doubt. Date 6 man to economist he day to the second and the day to the second and the s | TO THE FOLLOWING AREA DISCOURS AND ASSESSMENT AND ASSESSMENT AND ASSESSMENT AND ASSESSMENT ASSESSME | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| 1 - STATE REGISTRAR | STATE OF MARY | CERTIFIC | CATE OF | DEATH | MENIAL HYGIEN REG. NO | | | |
|--|--|--------------------------|-------------------|---|--|--------------|--------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Las | YiHON A | ustin | | | | 26 19 | YEAR 96 | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthdey) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTH | PLACE (State or Foreign |
| 164-24-0773 | 1 € M 2 □ F 7 | | NONTHS DAYS | HOURS MIN. | (Month, Day, Year) Apr. 23, 19 | | Country | nsylvania |
| Se. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TOWN | R LOCATION OF O | | 9c. COUN | | |
| Brooke Grove Numerican State 106. count Maryland Monts | | | Sandy | Spring | | Mon | tgom | nery |
| 10e. STATE 10b. COUR | | 10c. CITY, | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY LIMITS? |
| | gomery | Si | lver Sp | ring | | | | 1 ☐ YES ZY NO |
| 10a. STREET AND NUMBER | | | 101 | . ZIP CODE | | 10g. CITIZ | EN OF W | HAT COUNTRY? |
| 15100 Interlacher | | | | 20906 | | U.S | .A. | |
| 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 X YES | 2 NO | 13. WAS DEC | ENDENT OF HISPAN scify Cuban, Maxica | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) | s or No- | 14. RACE Black, | - American Indian, White, atc. |
| 3 Widowed 4 Divorced | IF YES, GIVE WAR OR I | DATES | 1 TYES | 2X NO Specify | y: | | Specif | |
| 15. DECEDENT'S EL | UCATION | 18a. DECEDENT'S U | SUAL OCCUPATION | ON | 16b. KIND OF BU | SINESS/INDL | | ite |
| (Specify only highest gra | Cotlege (1-4 or 5+) | | rk done during mo | | ISS. KIND OF BO | 311123711190 | No Thi | |
| 12 | consign (PT of ST) | Vice Pres | sident | | Construct | ion Co | mpan | ıy |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Malden | | | |
| Gordon J. Austin | 1 | | | Mary A | lice Small | ev | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DORESS (Street a | | Route Number, City or Tow | | Code) | 20906 |
| Honorah Austin | | 15100 | Interla | chen Dri | ve #808 Si | lver | Spri | |
| 20a. METHOD OF DISPOSITION 1 & Burlel 2 Cremetion 3 Re | 20 | h. PLACE AND DATE OF | DISPOSITION (Na | me of | DATE 200 LO | CATION - C | the or Tou | un Périe |
| 4 Donation 5 Other (Specify) | Ğ | ate of Hea | aven Cei | metery 1 | /30/965ilv | er Sp | ring | .Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE | ocepher /// | 111 | 22. NAME AP | ID ADDRESS OF FA | CILITY | | | |
| 1 /lach | 1/1/1/11 | | | | llins Fune | | | |
| 23. PARTY. Enter the diseases, o | complications that cause | d the death. Do no | t enter the mo | de of dulpo, eucl | y Blvd.,W. | SII. | Spr. | |
| anock, or haart fallure | . List only ona causa on o | each lina. | t ontar (no mo | an or aying, soo | ii aa cardiac or reap | iratory arre | wt, | Approximata Interval Between |
| IMMEDIATE CAUSE (Final disease or condition | 0.44 | | | | | | | Onset and Dea |
| resulting in death) | | MONIA A CONSEQUENCE OF): | | | | | | 5 DAYS |
| - | 000000000000000000000000000000000000000 | | | | | | | |
| Sequantially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| CAUSE (Disease or Injury | c | | | | | | | |
| that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| resulting in death) LAST | d | | | | | | | |
| PART II. Other significant condition | ona contributing to death i | but not resulting in | the underlying | cause given in | Part I. 24s, WAS AN | ALITOBEY | 1 245 | WERE AUTOPSY FINDING |
| PARKINSO | | | aria ariaariyii | oudse given in | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | 77722 771 | | | | 1 YES 2 | NO NO | | OF DEATH? |
| DID TORACCO USE | CONTRIBUTE TO | CALICE OF | DEATH N | 50 57 110 | | | | 1 YES 2 NO |
| DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE TO | CAUSE OF | | ES NO | | | | |
| EXAMINER? | HOSPITAL: | | THER: | ACE OF OEATH (Ch | | | | |
| 27. MANNER OF DEATH | 28a. OATE OF INJURY | 28b. TIME | | | 8 Other (Specify) 28d, DESCRIBE HOW I | N WIRY OCCI | IDEO | |
| 1 Natural 5 Pending | (Month, Day, Year) | INJUI | WO WO | RK? | ZOU, DESCRIBE NOW I | NJUNY OCCU | MEO | |
| 2 Accident investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJURY | Y — At home, ferm, str | | | 281. LOCATION (Street) | and Number o | r Burni Br | rute Mumber |
| 4 Homicide determined | building, etc. (Spe | icify) | | | City or Town, State) | | | , |
| 29a. CERTIFIER 1 M CERTIFYING PHY | SICIAN: To the heat of my leasur | dadas disabasas a | 246 47 44 | | | | | |
| | SICIAN: To the best of my know IER: On the basis of examination | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFI | | | y opinion, 0 | | | | | |
| A A A A A A A | mo | | | 29c. LICENSE NUN | ABER SY3 | 29d, DATE | - 1 | Month, Day, Year) |
| SQUAME AND ADDRESS OF PERSON W | NO COMPLETE OF THE | ATU /ITEM AT | infect. | | | | / | 6/96 |
| 3305 NONTH LE | ISM WSALD | OI I/A C | I VER | SPRIN | c mn 2a | C | The | es A. Ross |
| 31. DATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGN | PLVU. 31 | 200.0 | - 1 , 4// 4 | 7 111) 20 | 7 6 6 | 01111 | - 7. (7.003) |
| JAN 3 0 199 | | | | | | | | |





| executed within the hours after death. Page 6 may be retained by the hospital or attending physic | and completely filled in by the funeral director, page 5 should be detached for use as the buria | burial, cremation, or removal. | natic event, the medical examiner must be notified at once. | |
|--|---|--|--|--|
| TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physical properties of the properti | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumetic event, the medical examiner must be notified at once. | |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|---------|
| CERTIFICATE OF DEATH | REG NO |

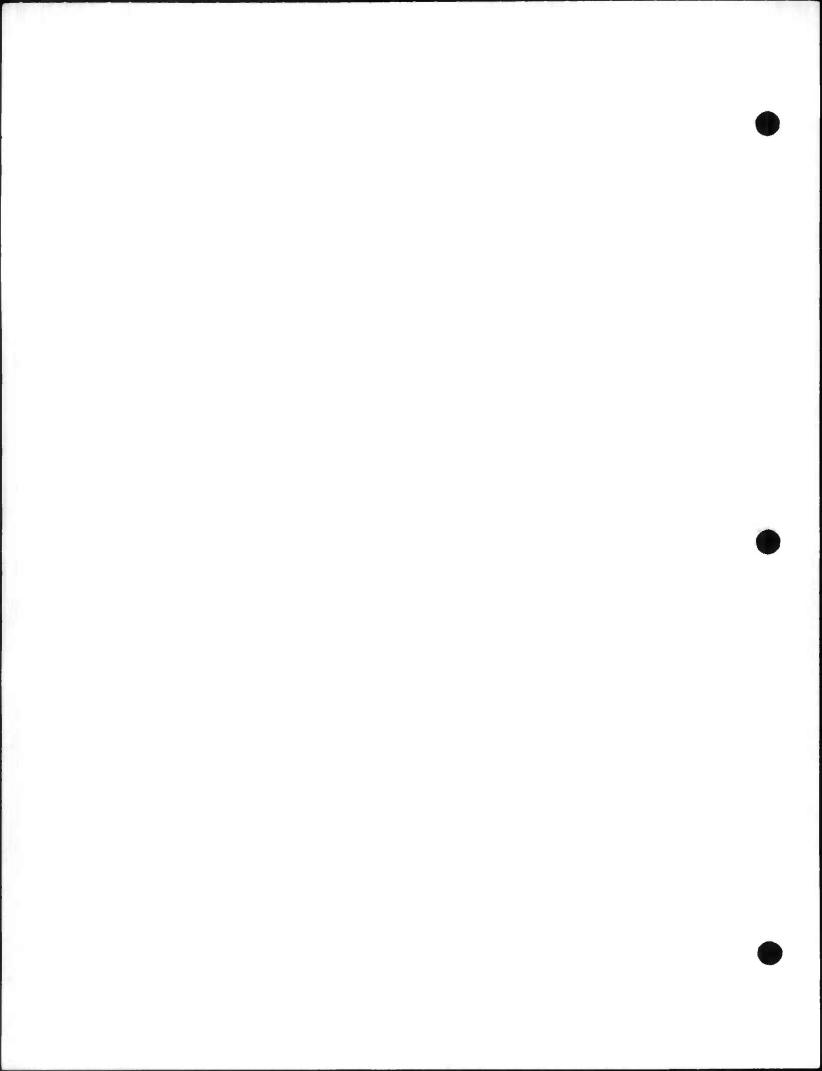
| | 1 - FOR STATE REGISTRAR | TE OF MARYLAN | D / DEPAR | TMENT OF I | HEALTH AND | MENTAL HYGIE | | | | |
|------------------|--|--|------------------------------------|-----------------------|---|--|---------------|------------------------|-------------------------------|------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEA | тн |
| | Maxme L | ouise | | Aik | eh | 1Q HUARY | 28 19 | YEAR | 410 | PM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In y | rs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | - | B. BIRTHPI | LACE (State or F | oreign |
| | 578-32-7625 1 D M | 12 X F 82 | YRS. | MONTHS DAYS | HOURS MIN. | July 16, | 1913 | Iowa | | |
| | Se. FACILITY NAME (If not institution, give street and it | number) | | 9b. CITY, TOWN | OR LOCATION OF DE | | _ | TY OF DEA | TH | |
| DIRECTOR | Shady Grove Adventist | Hospital | | Rockvil | le | | Mont | gomen | rv | |
| בו | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | |
| E | | | | , TOWN OR LOCA | | | | 1 | 0d. INSIDE CIT LIMITS? | Y |
| | Maryland Montgomer | у | Gait | hersbur | 0 | | | | YES 2 | NO |
| FUNERAL | | n 1 #0 | | | . ZIP CODE | | | | AT COUNTRY? | |
| N. | 18716 Walkers Choice | | | | 0879 | | | ed St | tates | |
| | 1 Never Married 2 Married FOR | B DECEDENT EVER IN U.: ICES? 1 TYES 2 | NO | 13. WAS DEC | ENDENT OF HISPAN ecity_Cuban, Mexica | HC ORIGIN? (Specify) in, Puerto Rican, etc.) | es or No- | 14. RACE - Black, 1 | - American Ind White, etc. | lan, |
| ΒY | 3 Widowed 4 X Divorced | ES, GIVE WAR OR DATES | В | t - YES | 2 NO Specify | | | Specify: | White | |
| <u>n</u> | 15. DECEDENT'S EDUCATION | 16 | DECEDENT'S | USUAL OCCUPATION | ON . | 16b. KIND OF B | 1500500000 | | WILLEC | |
| | (Specify only highest grade completed Elementary/Secondary (0-12) College | d) e (1-4 or 5+) | (Give kind of w life. Do NOT us | rock done during me | ist of working | 166, KIND OF B | USINESS/INDU | JSTHY | | |
| 7 | 2 | | Rudoet | Analyst | | U.S. Ar | mu Mat | oria | 1 Comm | and |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | Daaget | maryst | 18. MOTHER'S NA | ME (First, Middle, Maide | _ | erra | T COMM | and |
| 0 | Richard L. Voorhees | | | | | Toenjes | in sumame) | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street of | | Route Number, City or To | Ctata Tin | Co efe) | | |
| 2 | Thomas E. Ingalls | | | | | ville, Ma | | | | |
| | 20a METHOD OF DISPOSITION 1 M Burlet 2 Cremation 3 Removal from | 20b PL | | EDISPOSITION (No | | | OCATION - C | | | |
| | 1 X Buriet 2 Cremation 3 Removal from 4 Donation 6 Other (Specify) | State cemeter | y, crematory or oti | emorial | Dark | 1/31 Roc | | | | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | O | CLAWII II | | I ALK | CILITY | KATITE | , ma | гутапа | |
| - 1 | · ~ 7 TV | | | De Vol | Funeral | Home | | | | |
| _ | 7.00 | (| | 10 E. | Deer Par | k Dr., Ga | ithers | burg | , MD 2 | 0877 |
| | 23. PART i. Enter the diseases, or complica about, or heart failure. List only | itions that caused the one cause on each | e desth. Do n line. | ot anter tha mo | da of dying, auci | h as cardiac or rea | piratory arre | at, | Approxim | |
| | IMMEDIATE CAUSE (Final | | | | | | | | Onset an | |
| | disease or condition a. A | DUE TO (OR AS A CO | nchiolit | is with | h Asthma | | | | Day. | 5 |
| | | DUE TO (OR AS A CO | NSEQUENCE OF |): | | | | | , | |
| Z | Sequentially list conditions, | DUE TO (OR AS A CO | colory | infection | 4 | | | | wee | ks |
| Ě | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CO | NSEQUENCÉ OF |): | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury C. | DUE TO (OR AS A CO | NEEONENOS OF | | | | | | | |
| Ē | that initiated events resulting in death) LAST | DOE TO (OH AS A CO | MSECUENCE OF |): | | | | | | |
| iii iii | d | | | | | | | | - | |
| AL | PART II. Other aignificant conditions contrib | buting to death but r | | | | Part I. 24s. WAS A | N AUTOPSY | | ERE AUTOPSY F | |
| | Chronic Obstantive P. | ulmonary D | iscore | | | PERFO | PRMED? | C | MILABLE PRIOR DMPLETION OF | |
| | Hypertension Card | ice Arrhyth | | | | _ ' ' ' | 2 gg NO | | F DEATH? | |
| 5 | DID TOBACCO USE CONTRIBUTE | TO CAUSE OF D | EATH YE | NOL | UNCERTAIN | <u></u> | | Ι. | YES 2 | " [|
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | 26. 1 | | I (Check only one) | OTTOER()-(I) | · | | | | |
| Sic | EXAMINER? 1 YES 2 NO 1 I I I Inpu | ITAL: etient 2 - ER/Outpetier | nt 3 🗆 DOA | OTHER: | 5 🗆 Realdenca | 8 Other (Propile) | | | | |
| テ내 | | . DATE OF INJURY | 28b, TIME | OF 28c. INJ | URY AT | 28d. DESCRIBE HOW | INJURY OCCL | IRED | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJU | | RK? 'ES 2 NO | | | | | |
| BÁ | 2 Decident | . PLACE OF INJURY - A | At home, farm, st | reet, factory, office | | 26f. LOCATION (Street | and Number o | r Rumit Rou | te Number | |
| Ĕ | 4 Homicide determined | building, etc. (Specify) | | | | City or Town, State |) | | | ļ |
| וני | 29a. CERTIFIER 1 60 CERTIFYING PHYSICIAN: To a | he heat of our brounds do. | | | | | | | | |
| COMPLETED | (Check only one) 1 CERTIFYING PHYSICIAN: To to MEDICAL EXAMINER: On the | | | | | | | | | |
| ႘ႃ | 29b. SIGNATURE AND TIXLE OF CERTIFIER | | | , in my opinion, o | | | nd dua to the | cause(a) ai | nd menner aa s | tated. |
| 8 | A . /1 | 1.0 | | | 29c. LICENSE NUM | | | | onth, Day, Year) | 01 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLE | * | ATEN | 21.0 | | 142 | | nary | 29,19 | 96 |
| | BYRL D. JOHNSON | | (ITEM 27) (Typo, I | rint) | 0 | athershung | m 0 | 0 445 | ic. | |
| | | | | -III Proc | TIME U | with consulty | עוין. | 7081 | 1 | |
| | | REGISTRAR'S SIGNATUR | | | | | | | | |
| | JAN 3 0 1996 Jul | in Davidson R | ardalle | | | | | | - | |
| | | | | | | | | | District of | |

| BALLIMORE, MARYLAND | it 24 hours after death. Page 6 may be retained by the ho | by filled in by the funeral director, page 5 should be detact | abon, or removal. | , the medical examiner must be notified at once | |
|---|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68/60 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | be ned written 72 hours after dearn with the state Dept. of Health and Mental Hyglene prior to burnal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - STATE REGISTRAR | STATE OF M | | CERTIF | | | | | | | _ | | |
|----------------------------|---|--|---|---|---|--|--|-------------------------------|---|---|--|-------------|--------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | CERTIF | ICAII | E OF | DEA | П | 2. DATE OF | REG. NO. | | | |
| | Lucille Col | | A = *** | | | | | | MONTH | DA | | YEAR | 3. TIME OF DEATH |
| | LUCITIE COLTON Aarons (4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. las | | | | IF (INDE | R 1 YEAR | IF UNDER | | January | | 1996 | | 2:50 A. M |
| | 582-28-5403 | 1 🗆 M 2 💢 F | 83 | YRS. | MONTHS | - | HOURS | MIN. | (Month, De | ly, Year) | | Country | |
| | 9a. FACILITY NAME (If not institution, give | | 0.5 | - | Dh CIT | TOWN C | R LOCATI | 211 05 05 | | er 16, | | | Mary's,Md. |
| Œ | | | | | | | | ON OF DE | EAIH | | | ITY OF DE | |
| DIRECTOR | St. Mary's Nursing | Center | | | Leon | nardto | OWN | | | | St. | Mary' | S |
| Ä | 10a. STATE 10b. COUNT | гу | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY |
| | none n | one | | Wa | shir | igtor | ı, D. | C. | | | | | LIMITS7 1 1 YES 2 NO |
| AL | 10e. STREET AND NUMBER | | | | | 101 | ZIP COD | E | | | 10g. CITIZ | ZEN OF W | HAT COUNTRY? |
| E | 3745 W Street, | N.W. | | | | | 200 | 07 | | | U | .S.A | • |
| BY FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN FORCES? 1 | | | 13. | WAS DEC | ENDENT C | F HISPAN | IIC ORIOIN? (S | pecify Yes | or No- | 14. RACE | - American Indian, Whita, atc. |
| × | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE W | | | | | 2 X NO | | n, Puarto Rica : | 1, atc.) | | Specif | |
| | 15. DECEDENT'S EO | <u> </u> | | | | | | | | | | whit | <u>e</u> |
| COMPLETED | (Specify only highest grad | le completed) | | (Give kind of the Do NOT up | work done | during mos | ON st of workin | g | 16b. KIN | D OF BUS | INESS/IND | USTRY | |
| 1 | Elementary/Secondary (0-12) | College (1-4 or 5 d | +) | admini | , | | 200 | 1 + | | I.A. | | | |
| ₩. | 17. FATHER'S NAME (First, Middle, Last) | - | | aduitii | LOCIC | LLIVE | | | | | | _ | |
| ŏ | Richard J. Colt | OB | | | | | | | ME (First, Middle Hodges | | Sumame) | | |
| BE | 19s. INFORMANT'S NAME (Type/Print) | OII | | 10h MAH INC | ADDRESS | D /On1 | | | Route Number, (| | | | |
| 5 | Richard Colton | | - 1 | | | | | | Bowie | | | | |
| | 20a. METHOD OF DISPOSITION | | 205 81 4 | CEANDDATE | | | | na., | | | | | |
| | 1 € Surfel 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify) | noval from State | cometery Dark | cremetory or o | ther plece | O T W | Tan | 26 0 | DATE | | Lazi 1 | | m, State Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE | 2/1 | CLAWII (| | | D ADDRES | | | ROC | RVII | 10, | Tally land |
| | 1 C/2 C | DP411 | /// | | | | | | Home | | | | |
| | Jemes (| 196 | 4 | | 2 | 2222 | Wisc | onsi | in Ave | .,N.W | I.,Wa | sh., | DC 20007 |
| | 23. PART Enter the diseases, or shock, or heart failure. | List only one cau | t caused the sa on each | dasth. Do r line. | ot entar | the mod | da of dyl | ng, auci | h aa cardiac | or respir | atory arre | est, | Approximata Interval Batwean |
| | IMMEDIATE CAUSE (Final disease or condition | | | | 4 | 1 | 1 | | - | | | | Onset and Death |
| | resulting in death) | e Lee | nec | ISEQUENCE O | 4 | 1 | 14 | 5 > | lam | ne | Q_{-} | | YRE. |
| | | DUE TO | (OR AS A CON | ISEOUENCE O | F): | 11 | | | | | | | |
| CERTIFICATION | Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| ¥ | If any, leading to immediate cause. Enter UNDERLYING | any, leading to immedista | | | | | | | | | | | |
| 윤 | CAUSE (Disease or Injury that initiated events | c | (OR AS A CON | SEQUENCE OF | ŋ: | | | | | | | | |
| E | resulting in death) LAST | 4 | | | | | | | | | | | İ |
| | | u | | | | | | | | | | | |
| ¥ | PART II. Other algnificant condition | na contributing to | dasth but n | ot resulting | n the un | darlying | csuse g | Iven in | Part I. 24s | . WAS AN A | | | WERE AUTOPSY FINDINGS |
| PERFOR | | | | | | | | | 10 | YES 2 | | | COMPLETION OF CAUSE OF CEATH? |
| 0 | | | | | | | | | ->/ | / | | - | T YES 2 NO |
| MEDICAL | - | | | | | | | | | | | | /\ |
| | DID TOBACCO USE CONT | RIBUTE TO CA | | | | | UNC | ERTAIN | 1/4 | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | EATH YE | H (Check | only one) | UNC | ERTAIN | A | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | 26. P | LACE OF DEAT | H (Check | only one) R: sing Home | 5 🗆 Re | | 8 Other (Sp | ecify) | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: | 26. P ER/Outpatien INJURY | 1 3 DOA | H (Check | only one) R: sing Home 28c. INJU | 5 - Re | sidenca | 71 | | JURY OCC | URED | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, De | 26. P ER/Outpatlers INJURY ay, Year) | LACE OF DEAT | OF URY | only one) R: sing Home 28c. INJL WOF 1 Y | 5 Re | sidenca | 8 Other (Sp | | JURY OCC | URED | |
| ED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, Di | 26. P ER/Outpatlers INJURY ay, Year) | LACE OF DEAT | OF URY | only one) R: sing Home 28c. INJL WOF 1 Y | 5 Re | sidenca | 8 Other (Sp | N (Street an | | | ute Number, |
| ED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined | HOSPITAL: 1 Inputtent 2 28a. DATE OF (Month, Del) 28a. PLACE Of building, | 26. P ER/Outpetiers INJURY IN, Year) F INJURY — Al atc. (Specify) | 28b. TIM | H (Check | only one) R: sing Home 28c, INJL WOF 1 Y ory, office | 5 G Re | NO NO | 8 Other (Sp 28d. DESCRIE 281. LOCATIO City or To | N (Street an | d Number 6 | or Rural Ro | ute Number, |
| ED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, DL) 28a. PLACE Of building, ICIAN: To the best of | 26. P ER/Outpetien INJURY IN, Year) F INJURY — A etc. (Specify) | LACE OF DEAT 3 DOA 28b. TIM (NJ) t home, farm, s | H (Check OTHER 4X Num OF URY M M Marteet, fact | only one) R: sing Home 28c. JNJL WOF 1 Y ory, offica | 5 Re JRY AT RK? ES 2 and place, | NO NO and due | 8 Other (Sp 28d. DESCRIE 28f. LOCATIO City or To | N (Street an wn, State) | od Number o | or Rural Ad | |
| ED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, Di 28a. PLACE Of building. | 26. P ER/Outpetien INJURY IN, Year) F INJURY — A etc. (Specify) | LACE OF DEAT 3 DOA 28b. TIM (NJ) t home, farm, s | H (Check OTHER 4X Num OF URY M M Marteet, fact | only one) R: sing Home 28c. JNJL WOF 1 Y ory, offica | 5 Re JRY AT RK? ES 2 and place, | NO NO and due | 8 Other (Sp 28d. DESCRIE 28f. LOCATIO City or To | N (Street an wn, State) | od Number o | or Rural Ad | ule Number, and manner as stated. |
| COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, Di 28a. PLACE Of building. | 26. P ER/Outpetien INJURY IN, Year) F INJURY — A etc. (Specify) | LACE OF DEAT 3 DOA 28b. TIM (NJ) t home, farm, s | H (Check OTHER 4X Num OF URY M M Marteet, fact | only one) R: sing Home 28c. JNJL WOF 1 Y ory, offica | 5 Re JRY AT RK? ES 2 and place, | NO NO and due | 8 Other (Sp. 28d. DESCRIE 28f. LOCATIO City or To | N (Street an wn, State) and mann place, and | od Number of Num | d. | |
| BE COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIE | HOSPITAL: 1 Inputtent 2 28a. DATE OF (Month, Date of the building, build | 26. P ER/Outpetterr INJURY INJURY INJURY F INJURY — A etc. (Specify) my knowledge comination and | LACE OF DEAL 3 DOA 28b. TiM (NJ) t home, farm, a death occurre /or investigatio | H (Check. | only one) R: sing Home 28c. INJE WOF 1 Y ory, offica | b 5 Reb PRe PRE PRE PRE PRE PRE PRE PRE PRE PRE PRE | NO NO and due | 8 Other (Sp. 28d. DESCRIE 28f. LOCATIO City or To | N (Street an wn, State) and mann place, and | od Number of Num | d. | and manner as stated. |
| COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, D) 28a. PLACE Of building. ICIAN: To the best of ER: On the best of ex HO COMPLETEO CAUS | 26. P ER/Outpettery INJURY IN, Year) F INJURY — A etc. (Specify) my knowledge camination and | LACE OF DEAT 3 DOA 28b. TIM INJ 1 home, farm, s death occurre /or investigatio | H (Check. OTHER ALL Num OF URY M Intreet, fact And at the li n, in my o | only one) R: Sing Home 28c, INJL WOF 1 Y ory, office | o 5 Re Re RY AT RK? ES 2 and place, neth occur 29c. LICE | NO and due and at the NSE NUM | 8 Other (Sp. 28d. DESCRIE 281. LOCATIO City or To | N (Street an wn, State) and menn place, and | d Number of Number of Number of State of Number of State of Number | d. | and manner as stated. |
| BE COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIE | HOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, D) 28a. PLACE Of building. ICIAN: To the best of ER: On the best of ex HO COMPLETEO CAUS | 26. P ER/Outpettery INJURY IN, Year) F INJURY — A etc. (Specify) my knowledge camination and | LACE OF DEAT 3 DOA 28b. TIM INJ 1 home, farm, s death occurre /or investigatio | H (Check. OTHER ALL Num OF URY M Intreet, fact And at the li n, in my o | only one) R: Sing Home 28c, INJL WOF 1 Y ory, office | o 5 Re Re RY AT RK? ES 2 and place, neth occur 29c. LICE | NO and due and at the NSE NUM | 8 Other (Sp. 28d. DESCRIE 281. LOCATIO City or To | N (Street an wn, State) and menn place, and | d Number of Number of Number of State of Number of State of Number | d. | and manner as stated. |

32. REGISTRAR'S SIGNATURE

JAN 3 0 1996



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

| State of Maryland / | Department of | of Health and | d Mental Hygien |
|---------------------|---------------|---------------|-----------------|
| | | | |

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** JANUARY 24, 1996 **ASCHERMAN** 4:00 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7505 DEMOCRACY BLVD. #421A BETHESDA MONTGOMERY Hours Min. SEPT. Day, 7ea 1900 6. Sex 1 M 2 □ F If Undar 1 Yaar Months Days 5. Social Security Number 7. Aga (in yrs. last birthday) 9. Birthplaca (Stata or Foreign NEW YORK **Funeral** 95 270-20-4827 Yrs. **Director** Usuai Rasidance of Dacadant with the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits Pages 1 and 2 should be filed within 72 hours after death with the Manyan nent of Health and Mentai Hygiena.

Int: If item 27 is marked other than "natural", or items 23s or 28s-f show ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Evanture must be notified as 1 Yas 2 □ No Director MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7505 DEMOCRACY BLVD. #421A 20817 UNITED STATES Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marifai Status Black, Whita, atc. 1 Nevar Marriad 2 Married ☐ Yas 2 No f Yas, Giva Baltimore, Maryland 21215-0020 WHITE 1 Yas 2 No à Specify 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry College (1-4or 5+) Eiamantary/Secondary (0-12) ATTORNEY T.AW 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Surnama) Be IGNATZ **ASCHERMAN** MARY MERTZEL 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) Department of Health a Important: if item 27 is any injury or other tratence. MARGERY SHORR (DAUGHTER) 2684 SULGRAVE ROAD - SHAKER HEIGETS, OHIO 44122 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition
1 Burial 2 □ Crampalion 3 ■Ramoval from State 20c. Location - City or Town, Stata 4 Donation 5 Donar (Specify) MAYFIELD CEMETERY 1/29/96 CLEVELAND HGTS., OHIO 22. Nama and Addrass of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Part1. Exter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 Approximata Intervat Batween Onsat end Death Physician apply Kmia CondiAc immediata Causa (Finel disaasa or condition rasulting in deeth) /Medical Examiner Dua to (or as a consequenca of) Examiner The law requires that the death certificata be axecuted bunial-tran Sequantiatly list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury and Due to (or es e consequança of): Box 68760, physician Physician/Medical thet initiated avants rasulting in daath) Last the Dua to (or as a consaquanca of): 88 esn. Į O Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. P.O. be detached 23b. Did tobacco use contributa to the cause of death? erner's Sinner 2 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Wara autopsy findings available prior to complation of causa of daath? page 2 should Completed 24a. Was an autopsy performad? this certificata has 1 Yas 2 No 1 Yas 2 No or Attanding Physician: funeral director. 25. Was case referred to medicat axeminar?
1 ☐ Yes 2 No Be 26. Piece of Daeth (Check only one) Hospitai: Othar: 4 Nursing Homa 2 No Certification: To 1 ☐ inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 5 ☐ Rasidanca 6 ☐ Othar (Specify) 27. Menmer of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Panding death. 1 Yas 2 No Invastigation 2 Accidant after death Director: Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Spacify) in by 4 Homicide within 24 hours a To the Funeral D pelli Hospital 29a. Certifier 😢 Certifying Physician: To tha best of my knowledga, death occurrad at tha tima, data and place, and dua to tha causa(s) and manner as stated. Medical (Check only one) pletaly 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartific 0

State Registrar

31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura

LILA T. MCCONNELL, MD - 5530 WISCONSIN AVENUE #915 - CHEVY CHASE, MARYLAND 20815

Takin Davidson Randall

30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print)

Police in the Property Committee and the Committee of the

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| 3760 | |
| BOX 6876 | |
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| N OF VITAL RECORDS, | |
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| DIVISION | The second secon |
| D | |

| | | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH A CERTIFICATE OF DEATH | AND MENTAL HYGIE | | 30033 |
|---|-------------|--|---|---|--|
| | | 1. DECEDENT'S NAME (First, Middle, Leat) | 2. DATE OF DEATH | | E OF OEATH |
| | | Ella V. Brittingham | January | 22, 1996 7: | :25 a. M |
| P | | 16/-18-25// 1 M 2 M P / J YRS. | Men. 7. DATE OF BIRTH (Month, Day, Year) | 927 | (State or Foreign |
| . 3 should | 8 | Ba. FACILITY NAME (If not institution, give street and number) Edw. W. McCready Memorial Hospital Crisfield | OF DEATH | Somerset | |
| 5, 2, | CTOR | RESIDENCE OF DECEDENT | | | |
| permit. Pages | L DIRE | Md Somerset CrisFix | eld | Li | NBIDE CITY IMITS? YES 2 X NO |
| , 1 5 | FUNERAL | 3491 Freedom Town Rd. 218 | 817 | 10g. CITIZEN OF WHAT CO | DUNTRY? |
| 5-0020 Inding physician. Is the burial-transit | BY FU | 1 Never Married 2 Married FORCES7 1 YES 2 NO If yes, specify Cuban, | HISPANIC ORIGIN? (Specify Y Mexican, Puerto Rican, etc.) Specify: | be or No- 14. RACE - Ame Black, White, Specify: |) of _ |
| | | 16. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION | 16h KIND OF B | USINESS/INDUSTRY | MCN |
| poital or ed for u | COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) (Give kind of work done during most of working life. Do NOT upe retired.) ADD/VIII | | mstrizss | |
| The hospin detached | ON | 17. FATHER'S NAME (First, Middle, Last) | R'\$ NAME (First, Middle, Meide | | |
| 2 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 | BE | Hlonzo Brittingham to | ATTIE B | yerd | |
| retained 5 should notified | 5 | 19a. INFORMANT'S NAME (PyperPrint) 19b. MAILING ADDRESS (Street and Number or 7 49 1 5 5 7 7 9 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 | 1 10 | own, State, Zip Code) | 11 2,017 |
| 6 may be ector, page | | 20s. METHOD OF DISPOSITION 1 Sourisi 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, organishade oilling black) | DATE 200. L | OCATION - City or Town, State | 9,21811 |
| E 2 C | | 4 Donation 5 Other (Specify) | 27-96 W | Arion M | d |
| death. | | Huthey Ellan 314 Cove | St. Crist | eld Md. I | 21817 |
| within thours at pletely filled in by cremation, or remore, the medic | | 23. PART I. Enter the displace, or complications that caused the deeth. Do not enter the mode of dying shock, or heart feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) DUE TO (DR AS A CONSEQUENCE OF): | m | Ir o | Approximate interval Between Onset end Death |
| ocertificate be executed nding physician and con Hygiene prior to burial, or other traumatic en | RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | livee | | on on this |
| L H RE B | CER | d | | | |
| s that the death med by the atter alth and Mental | MEDICAL (| PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause give | | PRMED? AWAILAE | AUTOPSY PINDINGS BLE PRIOR TO ETION OF CAUSE ITH? |
| w requires that the pt. of Health a | M | DID TODACCO HEE CONTRIBUTE TO CALLED OF DELL'S AND TO THE STATE OF THE | | 1 🗆 YE | ES 2 NO |
| 2 2 2 2 | AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCER | RTAIN 🗆 | | |
| - F 2 % 6 | SIC | EXAMINER? HOSPITAL: OTHER: | | | |
| F # # 5 | PH | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? M 1 7 YEB 2 N | 28d. DESCRIBE HOW | INJURY OCCURED | |
| TTENDI TOR: A after 6 | TED BY | Suicide Could not be determined 28e. PLACE OF INJURY — At home, farm, etreet, factory, office building, stc. (Specify) | 28f. LOCATION (Street City or Town, State | t end Number or Rural Route Nun e) | nber, |
| ₹ 42 ± | MPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my policion, double countries. | nd due to the cause(s) and ma | inner as stated. | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: H | BE CO | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENS | | 29d. DATE \$IGNED (Month., | |
| 5 5 5 W | 10 B | 1. 0. Barhan 12 | 764 | 1/22/ | 96 |
| | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. Barhan, 4384 Crisfield Highway, Crisfield, | Md. 21817 | | |
| | | 31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE JAN 2 9 1996 Fals d'Audion Rardell | | | |
| | | JAN2 9 1996 Julia d'Avulean Rardell | | | |

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | | |
|------------------|---|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) ELMER C. BALLARD | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH 996 5:50 P M | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) F UNDER 1 YEAR F UNDER 24 HRS. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 7. DATE OF BIRTH (Month Day, Year) 5-1-1915 | 8. BIRTHPLACE (State or Foreign Country) NTY OF DEATH | | | | |
| TOR | Salisbury Nursing & Rehab Center salisbury, Mary | | COMICO | | | | |
| DIRECTOR | Md. SOMETSET WESTONET | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 101. ZIP CODE 218 | 71 | U.S. | | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES GIVE WAR OR DATES 1 YES 2 NO Specify Cubsn, Maxi | | 14. RACE — American Indian, Black, White, atc. Specify: Black | | | | |
| LETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | Industr | 1 1 | | | | |
| E COMPLET | 17. FATHER'S NAME (Figs, Middle, Lest) 18. MOTHER'S 18. MOTHER'S 18. MOTHER'S | NAME (First, Middle, Maiden Symame) | | | | | |
| TO B | 180. INFORMANT'S NAME (Type/Print) CRIZSTING BALLARD 5117-17 M.E. | el Route Number, City or Town, State, Zi WAShington | D.C. 20011 | | | | |
| | 20a. METHOD OF DISPOSITION 1 | 1-27-9 WEST | City or Town, State | | | | |
| | 22. NAME AND ADDRESS OF 30639 The | Empden Ave. | md. 21853 | | | | |
| | 23. PART I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, as shock, or bear failure. List only one cause on each line. IMMEDIATE CAUSE (Final discess or condition | uch as cardiac or respiratory as | Approximate Interval Between Onset and Death | | | | |
| | resulting in death) Dide-to (on as a consequence on): | CHT | Bis- | | | | |
| CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | el. COPF |) gens | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A COMMEQUENCE OF): OUT TO (OR AS A COMMEQUENCE OF): OUT TO (OR AS A COMMEQUENCE OF): | | | | | | |
| AL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given | Part I. 24s. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTA | AIN 🗆 | 1 YES 2 NO | | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | e 6 Other (Specify) | | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28s. DATE OF INJURY 26b. TIME OF 1NJURY WORK? 1 Accident Investigation | 28d. DESCRIBE HOW INJURY OF | CCURED | | | | |
| <u> </u> | 3 Suicide 6 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 261. LOCATION (Street and Number City or Town, State) | er or Rural Route Number, | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and do not not not not not not not not not no | | | | | | |
| TO BE (| 296. SIGNATURE AND TILL OF CERTIFIES A | 9349 P | TE SIGNED (Month, Day, Year) | | | | |
| | 30. NAME AND ADDRESS OF PERIOD OF COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print) William Robins M.D. 1104 HEALTHWAY DR., SALISB | URY, MD, 21804 | | | | | |
| | JAN 2 9 1996 Julia d'Aurelian Landall | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

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PHYSICIAN: MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran be filled within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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|---|

96 03637 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR Charlotte Virginia Butler 1996 10:50PM January 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Formion IF UNDER 24 HRS. June 3, 1908 577-42-9073 87 1 M 2 X Virginia Se. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince Frederick Calvert Calvert County Nursing Center RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? Calvert Prince Frederick Maryland 1 - YES 2 - 10 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Calvert County Nursing Home 20678 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, While, etc. 1 Never Married 2 Merried Il yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify: ₩X Widowed 4 Divorced Caucasian 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only Elementary/Secondary 8th N/A Clerk Election Office Upper Marlboro 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Flora Lee Taylor Charles Braun 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2477 Jackson Street San Francisco CA 94115 Carleen Keating 20e METHOD OF DISPOSITION
1 Duriel 2 Cremetion 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of Jan. 31) DATE 20c. LOCATION - City or Town, State emetery, cremetery or other place)
Southern Memorial Gardens 1996 Dunkirk, Maryland 4 Donellon 5 Other (Specify) 22. NAME AND ACCRESS OF FACILITY Lee Funeral Home, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 6633 Old Alexandria Ferry Rd Clinton, Md20735 23. PART I. Enier the deeses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition reauiting in death) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseasa or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not requiting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one

| To the Grot HE ETHED TO MEDICAL | | | only only | | | | |
|---|---|-----------------------------|----------------------------------|---|--|--|--|
| EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 | DOA OTHE | R: rsing Home 5 - Residence | 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending 2 Recident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, term, streat, lec | tory, office | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 299. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated. | | | | | | | |

| 29e. CERTIFIER (Check only one) | TO CERTIFYING PHYSICIAN: To the best of | | time, date end place, end due to the cause(a) a opinion, death occured at the time, date end place. | nd manner as stated. ace, end due to the ceuse(s) end manner ee stated. |
|---------------------------------------|---|---------|---|--|
| 29b. SIGNATURE | and titupor centinen which al | Brother | 29c. UCENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) 1 - 30 - 9 G |

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| J. Michael Bro | ooks M.D. 1 | 10 Hospital | Drive | #204 | Prince | Frederick | Md | 20678 |
|----------------|--------------------------|-------------|-------|------|--------|-----------|----|-------|
| JAN 3 0 1996 | 32. REGISTRAR'S SIGNATUR | Randall | | | | | | - |

32. REGISTRAR'S SIGNATURE Julia Davidson Rardall 1 G

Pages 1, 2, 3 should permit. use as the burial-transit Q 5 should be F notified a pe must funeral director, examiner the medicai filled in by 0 the premation event, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed burial, traumatic and 2 prior other signed by the attending phy Health and Mental Hygiene 10 injury, any shows a has be Dept. t 23 sh Item certificate h of the this c. marked, After 69 DIRECTOR: / 28 Пеш FUNERAL WITHIN 72 h HOSPITAL = **MPORTANT**: 五年書 223

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AMENDED #6, 1/24/96, B.P., WORCESTER CO. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH t. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2325 Elsie 01/18/1996 M Tarr 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5 SEX 6. AGE (In yrs. lest birthday IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 M 2 F 91 90 220-34-9300 02/16/1905 9e. FACILITY NAME (If not institution, give alreet end number) 95 CITY TOWN OR LOCATION OF BEATA 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Worcester Stockton 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5213 Big Mill Road 21864 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yee, specify Cuben, Mexican, Puerto Ri

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify. BY 3 K Widowed 4 Divorced White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY Щ Elementery/Secondary (0-12) College (1-4 or 5+) COMPL 8 Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Sidney Tarr Sallie Redden BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zin Code) 2 Betty B. Porter 5222 Big Mill Rd., Stockton, Md. 21864 20e. METNOD OF DISPOSITION
1 № Buriel 2 □ Cremation 3 □ Removal from State 29b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Union Franklin City Cemetery Donetion 6 - Other (Specify) 1/21 Greenbackville, Virginia 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Melson Funeral Home PO Box 64, Pocomoke, Md. 21851 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) wast pulus 4 CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING IOR AS A CONSEQUENCE OF CAUSE (Disease or Injury that initiated events reaulting in deeth) LAST PÁRT II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 1 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL:
1 V Inpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 YES 2 NO ng Nome 5 🗆 Reeldence 6 🗀 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28d, DESCRIBE NOW INJURY OCCURED 28b. TIME OF 26c. INJURY AT WORK? INJURY 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be ETED 4 Homicide 29e. CERTIFIER

**Chark and to CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner se atated COMPL 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion,

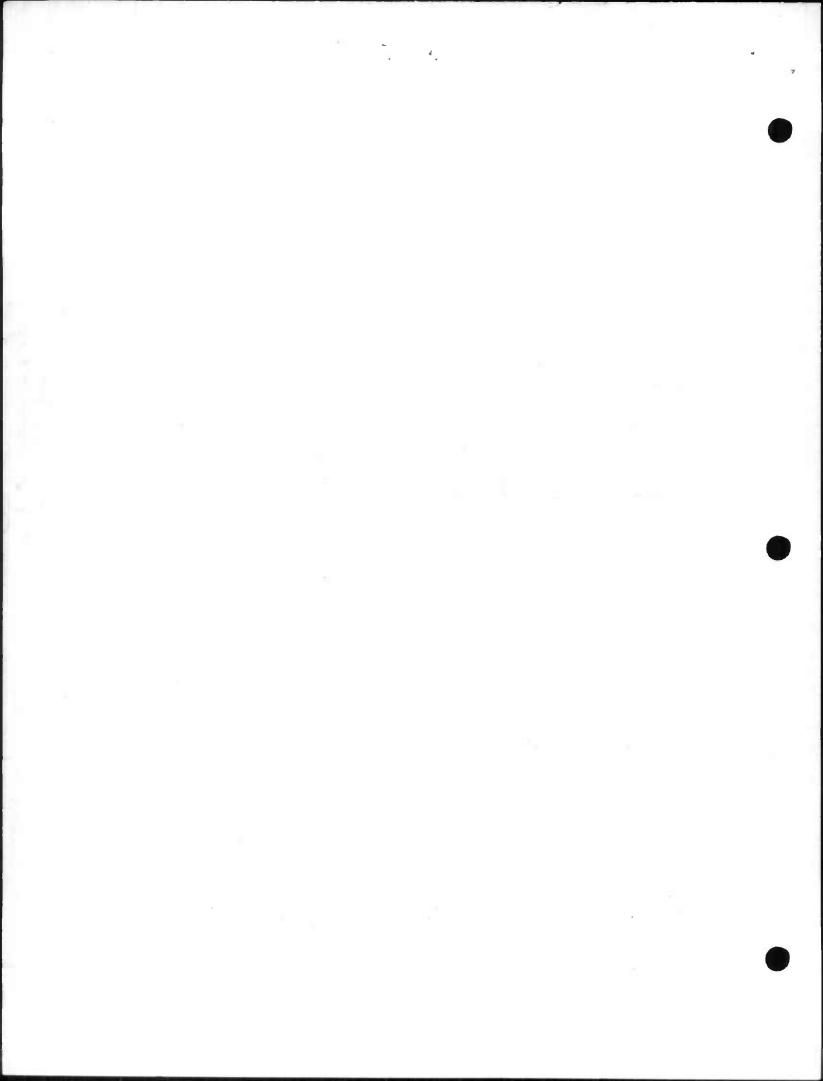
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Robins MD. 1104 Healthway Drive, Dr. William 31. DATE FILED (Month, Day.

29c. LICENSE NUMBER

32. REGISTRAR'S SIGNATURE **JAN 24**

29d, DATE SIGNED (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending p TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be find within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once. |
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|---------------|--|---------------------|---------------------------------------|----------------|--------------|------------|----------------|-------------|------------|-----------------------|---------------|----------------|------------------|--------|
| | 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / | DEPAR | TMEN ICAT | T OF I | IEALTH DEAT | AND I | MENTA | L HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | _ | | | | 2. DATE | E OF DEATH | | 3. | TIME OF DEA | TH |
| | FRANCIS | | JAMES BASSETT, SEFEBRUARY | | | | | | | "a. ı | 996 | 1.15 | 0 4 | |
| | | SEX | 6. AGE (In yrs. In: | st birthday) | | R 1 YEAR | IF UNDER | | 7 DATE | OF BIRTH | 0-11 | | ACE (State or Fi | ornion |
| | 476-26-3383 | XM2□F | 65 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Mon | th, Day, Year) | 120 | Country) | | - |
| | 9e. FACILITY NAME (If not institution, give stree | f and number) | | - | 01 017 | | OR LOCATIO | | 00 | i. J,1: | | | DAKOT | A |
| TOR | SHADY GROVE ADVENT | | PITAL | | | | /ILLE | ON OF DE | ATH | | 1 | TGOME | | |
| S | 10e. STATE 10b. COUNTY | | | I son CIT | V TOWN | 001004 | FION | | | | | | | |
| DIRECTOR | MARYLAND MONT | GOMERY | 10c. CITY, TOWN OR LOCATION ROCKVILLE | | | | | | | | 100 | LIMITS? YES 2 | | |
| | 10s. STREET AND NUMBER 10s. CITIZEN OF W | | | | | | | IZEN OF WHA | T COUNTRY? | | | | | |
| FUNERAL | 678 AZALEA DRIVE | | | | | | | 208 | 50 | | UNI | TED ST | TATES | |
| 5 | 11. MARITAL STATUS | . WAS DECEDEN | TEYER IN U.S. AF | RMED | 13. | WAS DEC | ENDENT O | F HISPAN | IC ORIGI | N? (Specify Yes | | | American Indi | |
| | 1 Never Married 2 Merried | FORCES? 1 | YES 2 1 | Ю | | If yes, sp | ecity Cuber | a, Maxicar | n, Puerto | Rican, etc.) | | Black, W | Thite, etc. | urt, |
| ВУ | 3 Widowed 4 Divorced | IF TES, GIVE W | AR OR DATES 1- | -1958 | | 1 YES | 2 🔀 NO | Specify | 7 | | | Specify: | WHITE | |
| | 16. DECEDENT'S EDUCAT | ION | 16a, DE | CEDENT'S | USUAL C | CCUPATI | DN | | 164 | b. KIND OF BUS | INESCIM | | | |
| COMPLETED | (Specify only highest grade cor Elementary/Secondary (0-12) | | (G | live kind of a | work done | during mo | as of workin | g | | s. Kille of eq. | HIVE US/ HIVE | 7001H1 | | |
| 7 | 12 | College (1-4 or 5 + | 1 | | | | ITROL | | | J. S. G | OVED | NIMENT | | |
| Ξ. | 17. FATHER'S NAME (First, Middle, Last) | | 7121 | 111/1 | 1110 | COL | | | _ | | | MMEMI | | |
| 8 | FRANCIS JAMES | DACCE | ст | | | | | | | Middle, Maiden | Sumame) | | | |
| 出 | | BASSE | | | | | OP, | * 644 | | IIGHT | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | | | | | | nber, City or Town | | | | |
| - | SARAH M. BASSETT | WI | E | 678 | AZAL | EA D | RIVE | , RO | CKVI | LLE, M | ARYL. | AND 2 | 20850 | |
| | 20a. METHOD OF DISPOSITION 1 General 2 Cremation 3 Remove | | 20b. PLACE | AND DATE | OF DISPO | SITION (Na | me of | | | | | City or Town, | | |
| | 1 ☐ Buriel 2 E Cremation 3 ☐ Remove 4 ☐ Donation 8 ☐ Other (Specify) | I from State | METRO | مل الماطار | Herolace, | CREM | ATOR | V 2 | /4/9 | | | | IRGINI | Λ 1 |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE | | | | | | | | | AAND | MIM, V | INGINI | . A |
| | marif N | Ba | 4/14. | | M | URIE | L H. | BAR | BER | FUNERA | L HOI | ME 20 | 0882 | |
| | mary N | . 1000 | THE C | | l P | .0. | BOX | 5038 | 8 L | AYTONS | VIII | F. MAR | CUAND | |
| | P.O. BOX 5038 LAYTONSVILLE, MAR 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | Approxim | ata | | | | |
| 1 | anock, or heart fellure. Lie | t only one cau | se on each line | | | | • | | | | | | Interval B | etween |
| - 1 | IMMEDIATE CAUSE (Final disease or condition | DIL | ما مسم لم | | RADU | | Da A | | | | | | Onset and | Death |
| | reaulting in dasth) a | | NARY | | | 7 >6 | 1-14- | | | | | | 1040 | and |
| | | DUE TO | OR AS A CONSE | QUENCE O | F): | | | | | | | | , | |
| Z | Sequentially list conditions, | | | | | | | | | | | | | |
| Ĕ | if any, leading to immediate | DUE TO | OR AS A CONSE | DUENCE O | F): | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | <u></u> | | | | | | | | | | | | |
| CERTIFICATION | that initiated events | DUE TO | OR AS A CONSE | DUENCE OF | F): | | | | | | | | | |
| E | reaulting in death) LAST | | | | | | | | | | | | 1 | |
| 2 | | | | | | | | | | | | | 1 | |
| 4 | PART II. Other algnificent conditions of | ontributing to | death but not r | esulting | in the u | nderlyin | g cause g | iven in i | Part I. | 24a. WAS AN PERFOR | | | RE AUTOPSY F | |
| MEDICAL | hug Concer | | | | | | | | | 1 TYES 2 | | co | MPLETION OF | |
| Ē. | | | | | | | | | | | 7 | - 1 | DEATH? | NO. |
| | DID TOBACCO USE CONTRIB | LITE TO CA | ISE OF DEA | TH VE | ं प्रत | NO [| LING | ERTAIN | | | | 1 | _ TES 2 _ I | 40 |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | OIL TO CA | | E OF DEAT | | | 0140 | LIVIAII | | | | | | |
| 길 | EXAMINER? | OSPITAL: | | | OTHE | | | | | | | | | |
| × × | | 1 | ER/Outpatient 3 | | | | e 5 🗆 Rei | sidence (| | | | | | |
| E | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | | | |
| BY | 2 Accident Investigation 2. PLACE OF IN HIGH. | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 田 | 4 Homicide determined building, atc. (Specify) | | | | | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER | | | | | _ | - | | | | | | | |
| 8 | (Check only one) | | | | | | | | | | | | | |
| Ö | 2 MEDICAL EXAMINER: C | on the beele of ex | emination end/or | Investigatio | n, in my e | opinion, d | eath occurr | d at the t | time, date | end place, en | due to th | e cause(e) an | d menner es s | inted. |
| M I | 266. SCHATURE AND TITLE OF CERTIFIER | 0 | | | | | 29c, LICE | NSE NUM | BER | | 29d, DAT | E SIGNED (Mr | onth, Day, Year) | |
| m / | entil A hour | bens | MN | | | | | 2-6 5 | | | ▶ Fi | | | 16 |
| 2 | 30. NAME AND ADDRESS OF PERSON-WHO C | OMPLETED CALL | - 1V/ | 4 0D (F | Ordens | | | | | | 100 | - 0 | 111 | 500 |

Frederich

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who completed cause of death (ITEM 27) (Type, Print)

Noenbarg MD

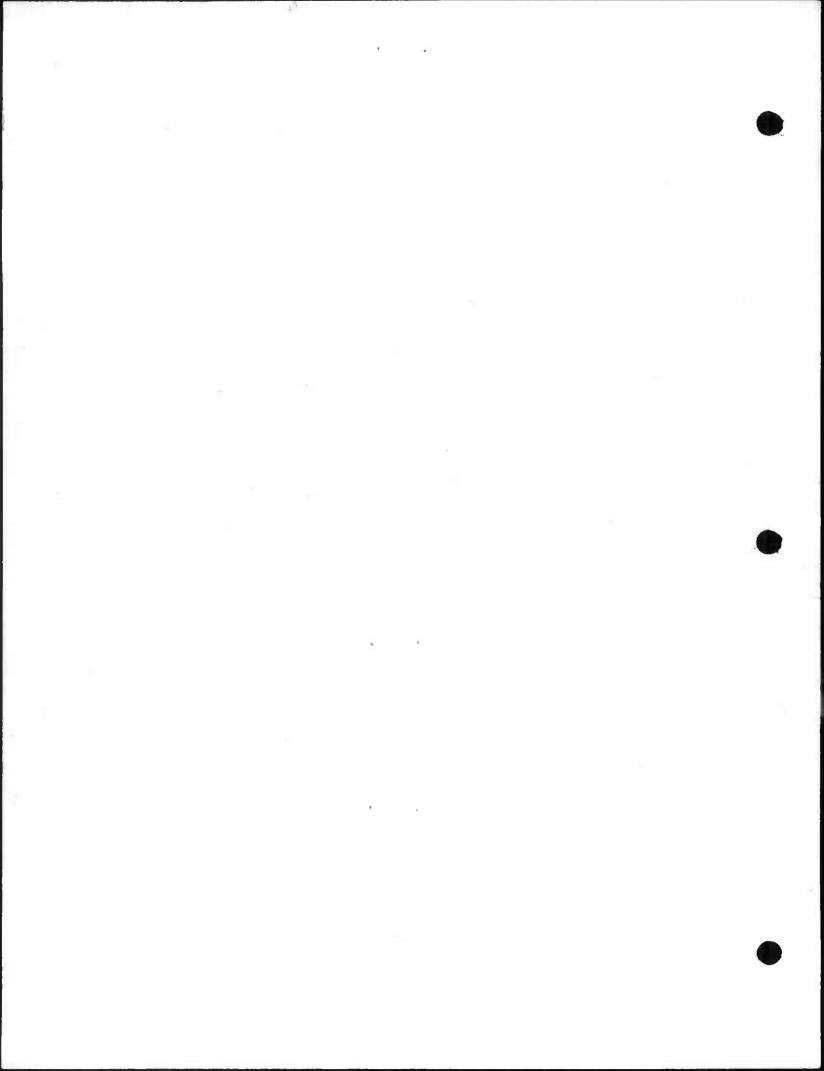
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31. DATE FILEO (Month, Dey, Year)

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| | 8 | IRE | E |
|) | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. P | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burital, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examin |
| | PITA | P. P. | 12 |
| | So | SIE | W |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR LARRY DEAN BARBER JAN 1996 1235 4. SOCIAL SECURITY NUMBER 8. AGE (in yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign IF UNDER 24 HRS. HOURE 1 X M 2 | F North Carolina 238-60-4566 55 OCT 20 1940 9a, FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10d. INSIDE CITY LIMITS? 1XXYES 2 NO N.C. 10c. CITY, TOWN OR LOCATION Stokes Pinnacle 10s. STREET AND NUMBER FUNERAL 10/ ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 117 Valley Green Trail 27043 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, atc.)
1 ☐ YES 2 ☑ NO Specify: Specify: white IF YES, GIVE WAR OR DATES BΥ 3 Wildowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 4 years owner/operator trucking 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname Irene Sutphin Bill Barber BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 27043 Shelia Barber 117 Valley Green Trail Pinnacle, N.C. 20a. METHOD OF DISPOSITION
1 Burial 2 Cramation 34 Ramoval from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Midkiff Cemetery / Jan. 20, 96 Mount Airy, N.C. 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY

Donaldson Funeral Home P.A. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE · Greys 313 Talbott Ave. Laurel, Md. 20707 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in deeth) 5 days PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): NON SMALL CELL LUNG CANCER 6 years CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING C. CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 XYES 2 NO 1 YES 2X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN :

36. PLACE OF DEATH (Check only one) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 Xinpatient 2 - ER/Outpatient 3 - DOA 1 - YES 2 1 NO 4 - Nursing Name 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 Natural
2 Accident

28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide 29s. CERTIFIER

(Chack only | 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

М

| 2 MEDICAL EXAMINER: On the basis of axa | amination and/or investigation, in my opinion, | death occured at the time, data and place, ar | id due to the cause(a) and manner as stated. |
|---|--|---|--|
| DE AND TITLE OF CERTIFIER | | On LACENCE MUMBER | and part could dive be well |

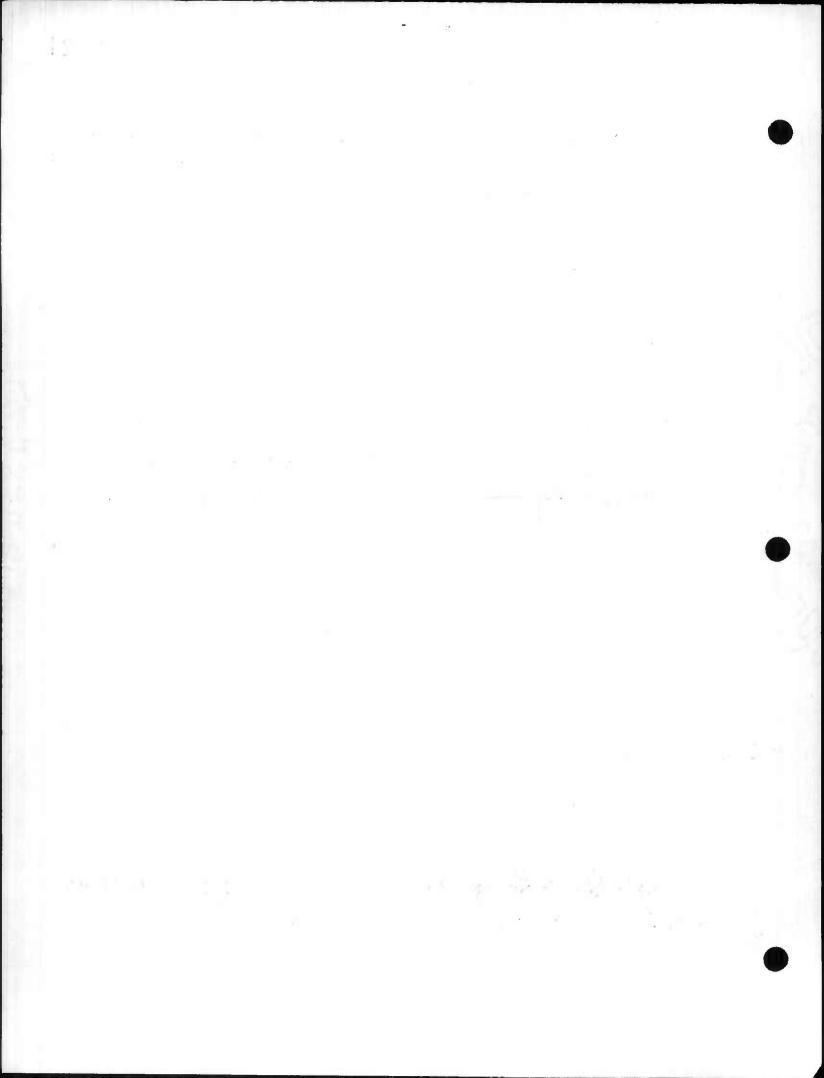
1 YES 2 NO

Sor PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAN. 17, 1996 MD-047454-L (PA)

NATIONAL NAVAL MEDICAL CENTER KELLOGG MC USNR RETHESDA MD 20889-5600

JAN 25 1996 TO REGISTRAN'S SIGNATURE

Investigation



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | MENTAL HYGIENE REG. NO. | | | | | | |
|------------------|--|--|---|---------------------------------|-----------------------------|--|------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | 2. DATE OF DEATH 3. TIME OF OE/ | | | | | | | | |
| | PAUL L | ESLIE | BRANSOI | V | | JANUARY 30 | | 0405 A M | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (Ir | yrs. last birthday) # | FUNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | THPLACE (State or Foreign | | | | |
| | 217-10-6356 9a. FACILITY NAME (If not institution, give s | 1X M 2 □ F 82 | 2 YRS. | DAYS DAYS | HOURS MIN. | | 913 County OF | WV | | | | |
| E | SACRED HEART HO | ALLEC | | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| H | 10a. STATE 10b. COUNTY | | | | 10d. INSIDE CITY LIMITS? | | | | | | | |
| | | eral | Ric | lgeley | | | | 1 TYES 2X NO | | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | | ZIP CODE | | | WHAT COUNTRY? | | | | |
| E I | Route 1 Box 51 | | | | 26753 | | USA | | | | | |
| | 1 Never Merried 2 X Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2X NO | If yes, spe | city Cuben, Mexica | NIC ORIGIN? (Specify Yes on, Puerto Rican, etc.) | Die | CE — American Indien, ick, White, etc. | | | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 TYES | 2 X NO Specif | y: | Spe | white | | | | |
| E | 15. DECEDENT'S EDU | CATION | 18a. DECEDENT'S US | UAL OCCUPATIO | N | 16b. KIND OF BUSI | NESS/INDUSTRY | WILLCE | | | | |
| COMPLET | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of world life. Do NOT use n | k done during mos etired.) | t of working | | | | | | | |
| P P | 12 | | Final 1 | Finish | Dept. | Tire | Company | 7 | | | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden S | umame) | | | | | |
| BE (| David Branson | 1 | | | Laur | ra (Abe) | | | | | | |
| 0 | 19s. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street ar | nd Number or Rural | Route Number, City or Town, | State, Zip Code) | 5 M . 18 | | | | |
| - | Josephine L. Br | | Route | 1 Box 5 | 1: Ridge | eley, WV 2 | 6753 | | | | | |
| | 20g. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 Rem | over from State 20b. | PLACE AND DATE OF D | | ne of | | ATION - City or | | | | | |
| | 4 Donation 5 Other (Specify) | I | ort Ashb | y Cemet | | | rt Ashb | y, WV | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 1/ | | D ADDRESS OF FA | ineral Home | | | | | | |
| | Hames - | + XICan | ouli | Cumb | erland. | MD 21502 | | | | | | |
| | 23. PART I Enter the diseases, or a | complications that caused | the death. Do not | | | | story arrest, | Approximate | | | | |
| | IMMEDIATE CAUSE (Final Ones the course of th | | | | | | | | | | | |
| Ì | disease or condition resulting in death) | KENA | CONSEQUENCE OF): | 1 LUK | E | | | TUR | | | | |
| | | 4 | | | | | | | | | | |
| Z | Sequentielly list conditions, | . HYPER | 2 TEN | SIDN | | | | 10 yrs | | | | |
| Ĕ | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | 1 | | | | |
| 5 | CAUSE (Disease or Injury | C. DUE TO (OR AS A | CONSEQUENCE OF): | | - | | | | | | | |
| Ē | that initieted events resulting in death) LAST | | , | | | | | | | | | |
| CERTIFICATION | | d | | | | | | | | | | |
| AL | PART ii. Other significent condition | s contributing to death bu | it not resulting in | the underlying | cause given in | Part i. 24s. WAS AN A PERFORM | | Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | |
| 8 | CARBION | YOPATHY | | | | 1 TES 2 | NO | COMPLETION OF CAUSE OF DEATH? | | | | |
| ME | SEPSIS | • | | | | | | 1 TES 2 NO | | | | |
| ä | DID TOBACCO USE CONT | | | | UNCERTAI | N 🗆 | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 6. PLACE OF DEATH | (Check only one) | | | | | | | | |
| YSI | 1 YES 2 NO | 1 Cinpetient 2 ER/Outpe | itient 3 DOA 4 | ☐ Nursing Home | | 6 Other (Specify) | | | | | | |
| | 27, MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME C | Y WO | RK? | 28d. DESCRIBE HOW IN. | JURY OCCURED | | | | | |
| BY | 2 Accident Investigation | | | | ES 2 NO | | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, atc. (Speci | (y) At nome, term, stre | et, rectory, office | | 261. LOCATION (Street an City or Town, State) | d Number of Rura | I Route Number, | | | | |
| THE P | 29e. CERTIFIER | | | | | 1 | | | | | | |
| AP. | (Check only | ICIAN: To the best of my knowle | | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINE | R: On the besis of exemination | and/or Investigation, | in my opinion, de | eath occured at the | time, data and place, and | due to the cause | e(e) and manner as stated. | | | | |
| BE | 296. SIGNATURE IND TITLE OF CERTIFIE | 1 -1 | | | 29c. LICENSE NUI | MBER | 29d. DATE SIGNI | ED (Month, Day, Year) | | | | |
| 10 | Taul J. O | uven good | MD | | 073 | 114 | JAN. | 30-46 | | | | |
| | 30 TO ME AND ADDRESS OF PERSON WE | A G - | I'M (ITEM 27) (Type, Pr | int) - | 7 4 | / / /// | | | | | | |
| | JAUL LIVENGOOD | 12 DECISTRADIO PICA | Jeton / | Trec | umbe | rland MD | 2150 | 2 | | | | |
| | JAN 31 1996 | 32. REGISTRAR'S SIGNA | what | | | - | | | | | | |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after defent, raye o may be received by the law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. John W. Roache, M.D.

31. DATE FILED AND 1996

| | FOR | STATE OF MA | ADVI AND / | DEDAD | TMENT | r oe u | EALTH AND I | MENTAI | HVOLEN | | 90 | 030 | 42 |
|----------------------|---|--|----------------------------------|---------------------------------------|-------------|----------------|---|------------------|---------------------------------|----------|--------------------------|--|-----------------------------------|
| | 1 - STATE REGISTRAR | SIAIL OF MA | | | | | DEATH | MENIA | REG. NO. | E | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE | OF DEATH | _ | | 3. TIME OF I | DEATH |
| | William G | | Be11, | Jr. | | | | Jan | uary 2 | 7, | 1996 | 7:39 | a. w |
| | 4. SOCIAL SECURITY NUMBER 220-03-7815 | 5. SEX 6 1 🔀 M 2 🗌 F | 3. AGE (In yrs. lest | birthday) | IF UNDER | 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE | OF BIRTH 19: | | 8. BIRTH | PLACE (State | or Foreign |
| | 9a. FACILITY NAME (If not institution, give str | reet and number) | | | 9b. CITY | , TOWN C | OR LOCATION OF DE | | | | UNTY OF D | | |
| TOR | Route 4 Box 141-A | | | | | Leon | ardtown | | | S | t. Ma | ry's | |
| DIRECTOR | Maryland Allega | | | | y, town o | | TON | · | | | | 10d, INSIDE LIMITS? 1 VES 2 | |
| FUNERAL | 100. STREET AND NUMBER 66 Douglas Avenu | ie | | | | | ZIP CODE | | | 10g. C | USA | WHAT COUNTR | 1177 |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 S IF YES GIVE WAI | TYPE 2 N | | | It yes, sp | ENDENT OF HISPAN ecity Cuban, Maxica 2 NO Specifi | n, Puarto f | 17 (Specify Yea Rican, etc.) | or No- | 14. RACI Biac What | E — American k, White, etc. | Indian, |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | (Gi | CEDENT'S ve kind of v Do NOT us | work done | during mo | DN st of working | 16b. | KIND OF BUS | iness/ii | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) William G. Bell Grace Mikesell | | | | | | | | | | | | |
| TO B | 100 INCOMANTIC NAME (Transferred) | | | | | | 1. 21 | 539 | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Seurlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemeiary, crematory or other place) Sunset Mem. Park Jan. 30, 1996 Cumberland, Md. | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | 22. Ei | chho | oning Mc | nzie | Funera | | | | |
| | 23. PART V Enter the diseases, or shock, or heart fallured IMMEDIATE CAUSE (Final disease or condition | | | | not enter | the mo | de of dying, suc | h as card | dac or reapi | ratory | arreat, | Interv | eximata ai Batween and Daat |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST RESCONAL F. DISPAST MERASTASES DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 81 | Mers. | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algolificant condition | s contributing to d | leath but not n | esulting | In the u | nderlyIn | g cause given in | Part i. | 24e. WAS AN PERFOR | MED? | Y 248 | D. WERE AUTOP AWAILABLE PI COMPLETION OF DEATH? | RIOR TO OF CAUSE |
| AN: N | DID TOBACCO USE CONTR | RIBUTE TO CAL | | TH YE | | NO X | UNCERTAI | Ν□ | | | | 1 TYES 2 | × 110 |
| 200 | EXAMINER? | HOSPITAL: | | | OTHE | B: | V B | 4 OH | or (Page 14.) | | | | |
| BY PHYS | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF II (Month, Day | YRULN | | | | | | | (A) | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide detarmined | 26a. PLACE OF building, a | INJURY — At ho- tc. (Specify) | me, tarm, | atreet, fac | tory, offic | a | 261. LOC City | ATION (Street or Town, State) | and Numi | ber or Rural | Route Number, | |
| COMPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | CIAN: To the best of n | | | | | | | | | | s) and manner | an stated. |
| BE | SID. STEMATURE AND TITLE OF CERTIFIER | | | | | | 29c, LICENSE NU | MBER | 7 | | | 27, 19 | |
| 5 | AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | OF DEATH (ITE | M 270 /5mg | Deint | | | - / | | 4 | 7 | 1 1 | |

Mechanicsville, Maryland 20659

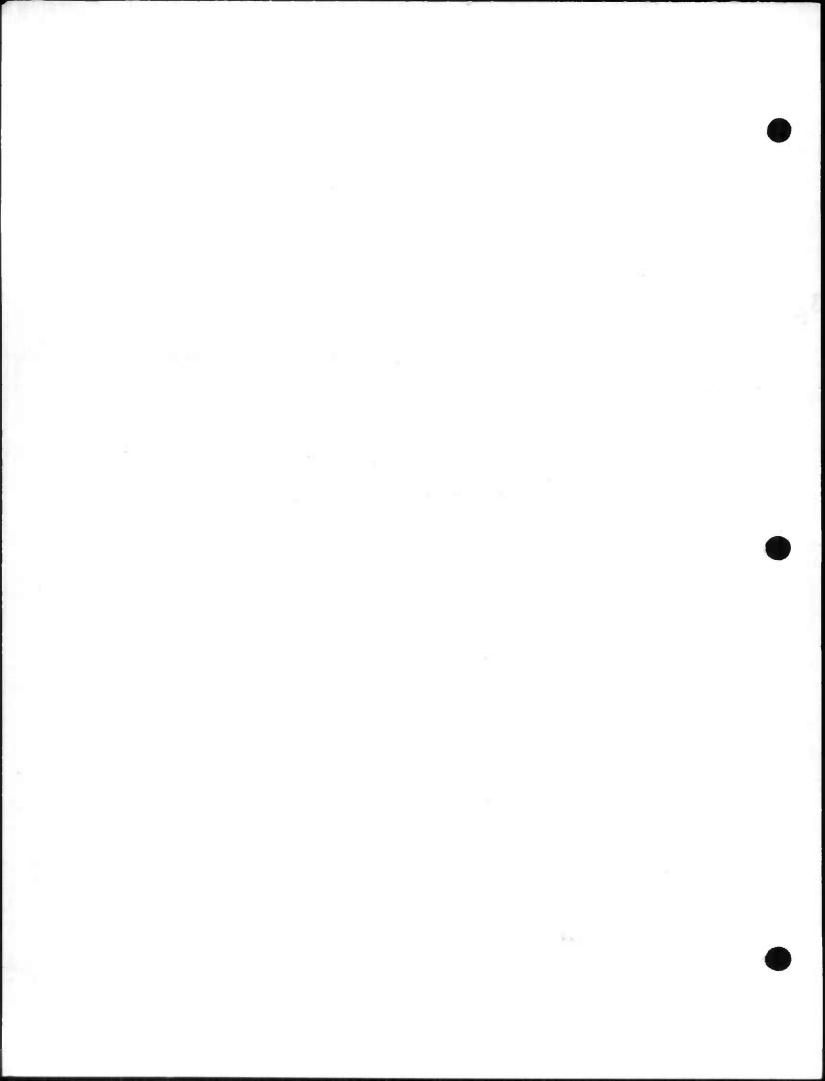
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1 - FOR STATE REGISTRAR

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| | | 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | | | | | | | | |
|---|--|---|---------------|----------------------|---|--------------|---|----------------------|------------|------------|-----------------------------|----------------|-------------|--------------------|-------------------|---|--|--|
| | | JOHN D | ARREL | ıL | | BUN | NER | | | | JANUAR | | | | 5:27 | Рм | | |
| | | 4. SOCIAL SECURITY NUMBER | BER | 5. SEX | 8. AGE (In yrs. Id | st birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF B (Month, Day | (RTH (Year) | | 8. BIRTH Countr | | Inside City Limits? Yes 2X No COUNTRY? Imerican Indian, ide, etc. Inte 21562 Bate MD Approximats Interval Between Onset and Death 3 Days 2 months 1 year ME AUTOPSY FINDINGS LABLET PRIOR TO DEATH? | | |
| 모 | | 415-66-2990 | | M 2 □ F | 52 | YRS. | | | | | Aug 5 | | 43 | | MD | | | |
| should : | стов | 9e. FACILITY NAME (If not in | | | | | OR LOCATIO | ON OF DE | ATH | | | NTY OF D | | | | | | |
| 1. 2, 3 | | MEMORIAL HO | ER | CUM | BERL | AND | _ | | | ALL | EGAN | Y | | | | | | |
| | REC | 10e. STATE | 10b. COUNTY | , | 10c, CIT | Y, TOWH C | OR LOCAT | TION | | | | | | 10d. INSIDE CIT | γ | | | |
| .j. | ō | MD | All | egany | | We | ester | npoi | rt | | _ | | | | |] NO | | |
| Deru | 3AL | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP CODI | E | | | | | VHAT COUNTRY? | | | |
| ransi | FUNERAL | 23816 Sto | ney Ru | | | | | | 2156 | | | | US | | | | | |
| priystoan. burlal-transit permit. Pages | | 1 Never Married 2 | Married | FORCES? | NT EVER IN U.S. A 1 YES 2V WAR OR DATES | NO | IO If yes, specify Cuben, Mexican, Puerto Rican, etc.) Blac | | | | | | Black | c, White, etc. | len, | | | |
| # 2 | ВУ | 3 Widowed 4 Dive | orced | IF YES, GIVE | MAH OH DATES | | | 1 YES | 2X) NO | Specify | / | | | Speci | white | | | |
| use as | ED | | EDENT'S EDUC | | | ECEDENT'S | | | | ng | 16b. KIN | D OF BUS | SINESS/INC | DUSTRY | WILLE | | | |
| 1 2 3 | LET | Elementary/Secondary (| 3-12) | College (1-4 or 5 | - 16 | e. Do NOT u | se retired.) | | | • | | | | | | | | |
| detached once. | COMPL | 12 | liddin I ant) | | | Owner | /0pe | rato | _ | | | | er Au | ito | | | | |
| at on | E C | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Florena (Wetzel) | | | | | | | | | | | | | | | | |
| 5 should be detached notified at once. | 00 | the INFORMANT'S NAME (Smaller) | | | | | | | | | | | Code) | | | | | |
| ge 5 st e noti | 2 | Brenda I. | 23816 | Sto | net/ | Pun | Road | SW W | octo | mm | rt i | MD 2156 | 2 | | | | | |
| P 2 | | 20e. METHOD OF DISPOSIT | 20b. PLACE | AND DATE | OF DISPOS | | | | DATE | | | City or To | | | | | | |
| director, p | | 4 Donation 5 D Other | (Specify) | | Sun | set M | emor | | | | 01/26 | Ct | mber | land | l, MD | | | |
| tuneral dir tuneral dir L examiner | | 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home | | | | | | | | | | | | | | | | |
| | | Jane | 01 | dica | upl | M | | Cumb | erla | nd. | MD 21 | | | | | | | |
| 2 2 2 3 | | 23. PART . Enter tha d | | omplications th | | | | | | | | or respi | ratory sr | rest, | | | | |
| y filled in tion, or the me | | IMMEDIATE CAUSE (Fi | | | | | | | | | | | | | | | | |
| poletely fille cremation, | | resulting In death) a. Multiple System Failure Due TO (OR AS A CONSEQUENCE OF): 3 Days | | | | | | | | | | | ys | | | | | |
| 8 6 4 5 | _ | | | | | | | | | | | | nthe | | | | | |
| and and | CERTIFICATION | Sequentially list conditions, if sny, leading to immediate b. Due to (OR AS A CONSEQUENCE OF): | | | | | | | | | | 10115 | | | | | | |
| 2 2 | CAT | csuse. Entar UNDERLY CAUSE (Disease or inju | ING | Duode | nal Ade | nocar | cino | ma | | | | | | | 1 yea | ar | | |
| ing phy giene p | E | thet initiated events | | DUE TO | OR AS A CONS | EOUENCE C | IF): | | | | | | | | | | | |
| the attending phy Mental Hygiene Jury, or other | H | resulting in death) LAST | | | | | | | | | | | | | | | | |
| that the treat ed by the att the and Menta any Injury, | | PART II. Other algorificent conditions contributing to desth but not resulting in the underlying cause given in Part i, 24s. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO | | | | | | | | | | | | | | | | |
| signed by the Health and Health and Im. | EDICAL | Dementia ? Alzheimer's | | | | | | | | | | | | | | | | |
| een sign of Heal | WE | | | | | | | | | | 1 YES 2 | NO | | | | | | |
| as becreept. | ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN | | | | | | | | | | | | | | | | |
| this certificate has be with the State Dept riced, or item 23 | 1CI | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | | | | | |
| r this certificate has been sin with the State Dept. of Hisarked, or Item 23 show | PHYSICIAN: | 1 YES 2 NO | | 1 Anpatient 2 | ER/Outpatient | 3 DOA | | sing Hom 28c. INJ | | esidence | 8 Other (Sp | | HILLIBY OC | CHIPED | | | | |
| offer this cleath with marked, | | 1 Natural 5 | Pending | | Day, Year) | | JURY M | WO | PRK7 | NO | 200.020011 | | | OUNED | | | | |
| After death | D BY | 2 Accident 3 Suicide 8 | Could not be | 28e. PLACE (| OF INJURY — At I | iome, Isrm, | street, fac | tory, offic | :0 | | 281. LOCATIO | N (Street | and Numbe | r or Rural F | Route Number, | | | |
| 28 after | ETEI | 4 Homicide | determined | bulluling | , etc. (Specify) | | | | | | City or To | wn, Stere) | | | | | | |
| DIRECT HOURS | PLE | 29a. CERTIFIER (Check only | TIFYING PHYSI | CIAN: To the best of | ıf my knowledge, α | leath occur | red at the t | lme, date | end place | , end due | to the cause(s | end mer | ner es ata | ted. | | | | |
| FUNERAL WITHIN 72 H | COMPL | one) 2 MED | ICAL EXAMINE | R: On the besis of | examination and/o | Investigati | on, in my o | opinion, d | leath occu | red at the | time, date end | place, an | d due to ti | he cause(s | s) end manner es | stated. | | |
| TO THE FUNERS TO THE FUNERS DE FIEED WITHIN 7 | ш | 296 BIGBIATURE AND FITLE | от вентина | 11 | 1 | - 7 | W 9 | 1 | 29c. LIC | ENSE NU | MREM | | 29d. DAT | E SIGNED | (Mordy, Day, Year | 1 | | |
| E S S E | D 14393 | | | | | | | | | 96 | | | | | | | | |
| | FREDERICK MILTENBERGER M.D., 625 KENT AVE., CUMBERLAND, MD 21502 | | | | | | | | | | | | | | | | | |
| 4 | | 31. DATE FILED (Month, Day, | | | | | AVE | ٠, ٥ | UMDE. | IVLAIN. | ט, מין | 213 | UZ | | | | | |
| | | JAN 2 | | Jabi d | AR'S, SIGNATURE | the th | | | | | | | | | | | | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

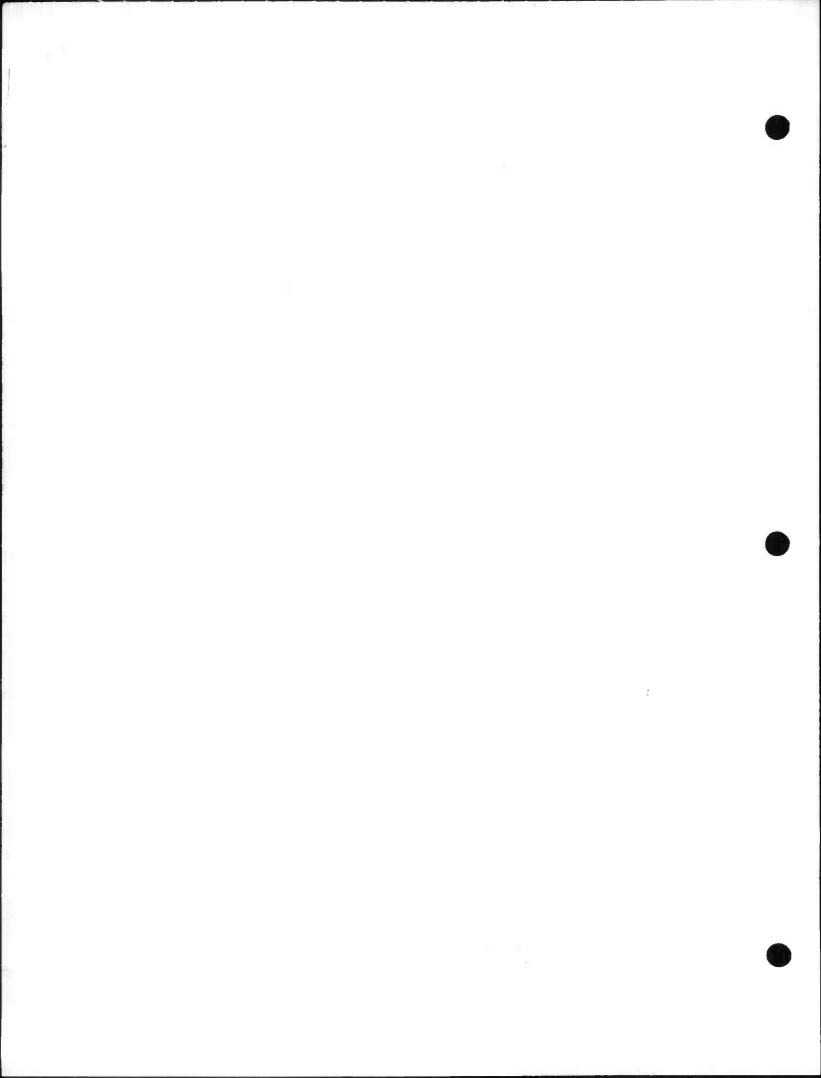
| | ages 1, 2, 3 should | |
|--|--|--|
| O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | d or flow 23 shows any injury or other traumatic event, the market averaging much his matthaut as account. |
| within 24 hours after | pletely filled in by the cremation, or removal | ant the madical |
| ertificate be executed | s certificate has been signed by the attending physician and completely filled in by the 1 the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | other traumatic ev |
| quires that the death of | n signed by the attend f Health and Mental Hy | nows any injury or |
| rSician: The law re | s certificate has bee th the State Dept. o | d. or item 23 st |
| R ATTENDING PHY | RECTOR: After this urs after death with | PORTANT: If Item 28 is marked |
| THE HOSPITAL OF | TO THE FUNERAL OIRECTOR: After be filed within 72 hours after death | IMPORTANT: If its |

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JAN 3 0 1996

| | 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / | DEPAR ERTIF | TMENT | OF H | EALTH DEAT | AND I | | HYGIENI REG. NO. | E | | | | |
|-----------------------|--|--|--|--|--|---|--|--|--|--|----------------------|-------|--|------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH DAY YEAR | | | YEAR | 3. TIME OF DEATH | | | | |
| | Margaret 4 SOCIAL SECURITY NUMBER | | Barclay | | | | | | Jan.26,1996 | | | | | Дм | |
| | | 5. SEX | NO. | | | | F UNDER 1 YEAR IF UNDER 24 HRS. WITHS DAYS HOURS MIN. | | | 7. DATE OF BIRTH (Month, Day, Year) | | | NPLACE (State or Foreign | 2 | |
| | 215-20-0975 | 1 M 2 F | 92 YRS. | | | | | | Mar.2,1903 | | 03 | | yland | | |
| nr. | 9e. FACILITY NAME (If not institution, give s | | 9b. CITY, TOWN OR LOCATION | | | ON OF DE | DEATH 9c. COUNTY | | | | | | | | |
| DIRECTOR | 145 Delaware A | | Salisbury | | | | | Wicomico | | | | ico | | | |
| EC | 10e. STATE 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDE CITY | | | | |
| 2 | Maryland Wicomico | | | | Salisbury | | | | | | | | LIMITS? | | |
| AL | 10e. STREET AND NUMBER | | 10f. ZIP CODE | | | | | | 10a, CIT | IZEN OF V | WHAT COUNTRY? | | | | |
| FUNERAL | 145 Delaware Avenue | | | | 21801 | | | | | | | | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U | | | S_ARMED 13. WAS DECENDENT OF HISE | | | | | | | | | Is RACE — American Indian, Black, White, etc. | | |
| | 1 Never Married 2 Married 3 Widowed 4 Divorced | YES 2 XI | S 2 NO If yes, specify Cuban, Mexico | | | | | n, Puerto Rica | in, etc.) | | Spec | | | | |
| COMPLETED BY | | | The special sp | | | | | | | | Black | | | | |
| | (Specify only highest grade completed) | | | | ind of work done during most of working | | | | | ND OF BUSI | OF BUSINESS/INOUSTRY | | | | |
| Ë | Elementary/Secondary (0-12) |) life | life. Do NOT use retired.) | | | | | | | | | | | | |
| MP | 12 | | Do | omes | tic | | | | | None | 2 | | | | |
| 00 | 17. FATNER'S NAME (First, Middle, Last) | | | | 16. MOTN | ER'S NA | ME (First, Midd | lle, Maiden S | Sumame) | | | | | | |
| BE | Charles Elzey | | | | | | Brow | | | | | | | | |
| 2 | | | | | | | | and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| | Debra Greene 408 Lake Street Salisbury, Md. 2 | | | | | | | | | | | | | | |
| | 20a, METHOD OF DISPOSITION Burlal 2 Cremation 3 Removal from State 20b. PLACE / Cemetery_cre | | | | and DATE OF DISPOSITION (Nerne of ematory of other piece) nghill Gardens | | | | | OATE 20c. LOCATION — City or Town, State | | | | | |
| | 4 □ Donation 5 □ Other (Specify) Sprin 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | ghill Gardens Hebron, Md | | | | | | d | | | | |
| | WA N | \ | Stewart Funeral Home | | | | | | | | | | | | |
| | Stadys B. Stewart | | | | 821 West Rd.Salisbury.Md.21801 | | | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| | shock, or heart failure. | complications that | caused the de | eth. Do r | ot enter | the mod | e of dyl | ng, suci | as cardiac | or respin | atory an | rest, | Approximate | | |
| | IMMEDIATE CAUSE (Final | List only one cau | se on each line | 9. | ot enter | the mod | e of dyl | ng, sucl | h as cardiac | or respin | atory an | rest, | Approximate interval Between | | |
| | snock, or neart failure. | List only one cau | se on each line | 9. | ot enter | the mod | e of dyl | ng, sucl | h as cardiac | or respin | atory an | rest, | Approximate interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition | List only one cau | se on each line | 9. | ot enter | the mod | e of dyl | ng, sucl | h as cardiac | or respin | atory an | rest, | Approximate interval Between | | |
| NC | IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Sind! DUE TO | OLN O | DUENCE OF | ot enter | the mod | e of dyl | ng, sucl | h as cardiac | or respin | atory an | rest, | Approximate interval Between | | |
| ATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | a. Sind! DUE TO | se on each line | DUENCE OF | ot enter | the mod | e of dyl | ng, sucl | h as cardiac | or respin | atory an | rest, | Approximate interval Between | | |
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MD 1104 L 32. REGISTRAR'S SIGNATURE Julia Davidson Roadell Dame SAcumo 21801



| TAL, DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | 4AL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral directior, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should | 72 hours after death with the State Dept. of Health and Mertial Hygiene prior to burlal, cremation, or removal. | If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|---|---|
| TO THE HOSPITAL DR ATTENDING | TO THE FUNERAL DIRECTOR: After | be filed within 72 hours after death with t | IMPORTANT: If item 28 is may |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|------------------|--|---|---------------------|---|----------------------|---|----------------------------|-----------------|----------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 02111111 | 10/11/2 01 | DENTI | | TE OF DEATN 3, TIME OF DEA | | | TIME OF DEATH | | |
| , | , | MARGARET | S. BR | RATTEN | | JAN | | 199 | AR . | 10:55A.M | | |
| | | | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE C | F BIRTH | 0.1 | BIRTHPLA | CE (State or Foreign | | |
| | 217-30-9625 9a. FACILITY NAME (If not institution, give street | M 2 F | 61 YRS. | MONTHS DAYS | HOURS MIN. | SEPT | Day, Year) | | | ID. | | |
| NO. | 7304 PARSONSBURG | | | | NSBURG | -AIRI | | | COMI | | | |
| <u> </u> | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | 10c, CIT | Y, TOWN OR LOCAT | | 104 104 | | | I. INSIDE CITY | | | |
| DIRECTOR | | OMICO | 0.00 | RSONSB | URG | | | | | LIMITS? YES 2 NO | | |
| 3 | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | | 10g. CITIZEN | | | | |
| ÿ | 7304 PARSONSBI | | | | | | | | . S . A | | | |
| FUNERAL | 11. MARITAL STATUS 12 1 Never Married 2 Married | . WAS DECEOENT EVER IN FORCES? 1 YES | 2 XNO | If yes, spe | ENDENT OF NISPAN | n, Puerto R | | or No — 14. | Black, WI | American Indian, hita, etc. | | |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 🗆 YES | 2 X NO Specify | y: | | | Specify: | WHITE | | |
| | 15. DECEDENT'S EDUCATI | ON | | USUAL OCCUPATION | | 16b. | KIND OF BUS | INESS/INDUST | RY | | | |
| E I | (Specify only highest grade com | ollege (1-4 or 5+) | (Give kind of a | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | |
| 1 | 12 | onege (1-4 of 5 +) | BUS CO | NTRACT | B | OARD | of E | DUCA | TION | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTNER'S NA | ME (First, N | fiddle, Malden | Sumame) | | | | |
| 0 | WILMER SHOCKL | ΕY | | | FLOR | A EM | MA C | ORDRE | Y | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | nd Number or Rural i | Route Numb | er, City or Town | , State, Zip Co | de) | 03040 | | |
| 5 | ALFRED BRATTEN | | 730 | 4 PARS | ONSBURG | ROA | D. P. | ARSON | SRIIF | 21849 RG. MD. | | |
| | 20a, METNOD OF DISPOSITION | | PLACEANDDATE | OF DISPOSITION /Na | me of | DATE | 20c. LO | CATION - City | or Town, | Stata | | |
| | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval 4 ☐ Donation 5 ☐ Other (Specify) | from Stata cem | orest | Grove | CeMETER | Y1/2 | 26 PA | RSONS | BURG | G, MD. | | |
| | THE SHOWATURE OF FUNERAL SERVICE LICENS | SEE / | 0 | 22. NAME AF | ID ADDRESS OF FA | CILITY | | | | | | |
| | BOUNDS FUNERAL HOME, SALISBURY, MD. | | | | | | | | | | | |
| | 23 PART I. Enter the diseases, or con | plications that caused | the death. Do | | | | | | | Approximate | | |
| | shock, or heart fellure. List only one cause on each line. | | | | | | | | | | | |
| | IMMEDIALE CAUSE (FINE) | | | | | | | | | | | |
| | disease or condition a. D: thuse Large Cell hymphone DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| _ | DUE TO (UN AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | | |
| AT | csuse. Enter UNDERLYING | | | | | | | | | | | |
| FIG | CAUSE (Disease or Injury that Initiated events | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | | | | |
| H | resulting in death) LAST | | | | | | | | | | | |
| | | | | | | ni a I | | | | | | |
| AL. | PART II. Other significant conditions of | contributing to death b | ut not resulting | in the underlyin | g cause given in | Part I. | 24a. WAS AN PERFOR | | AW | RE AUTOPSY FINDINGS AILABLE PRIOR TO | | |
| Dic | | | | | | | 1 TYES 2 | NO | | MPLETION OF CAUSE DEATH? | | |
| ME | | | | | | | | | 1 (| YES 2 NO | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIB | | | | UNCERTAI | N | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | 26. PLACE OF DEA | OTHER: | | | | | _ | | | |
| YSI | | ☐ Inpetient 2 ☐ ER/Outp | | 4 - Nursing Non | e 5 Rasidence | 1 | | | | | | |
| PH | 27. MANNER OF DEATN 1 Netural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIA | JURY WO | PRK? | 28d. DES | CRIBE HOW I | NJURY OCCUR | ED | | | |
| В | 2 Accident Investigation | | | | YES 2 NO | | | | | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY building, etc. (Spec | | street, factory, offic | | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | e Number, | | |
| ET. | 29a, CERTIFIER | | - | | | | | | | | | |
| COMPLET | (Check only one) 2 MEDICAL EXAMINER: | _ | | | | | | | ause(a) an | nd manner as stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 7 | | | 29c, LICENSE NUI | MBER | | 29d. DATE S | GNED (M | onth, Day, Year) | | |
| BE | A E. 2 | au . | м, О. | | 030 | 69- | | | 03 | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO C | COMPLETEO CAUSE OF DE | ATH (ITEM 27) (Type | a, Print) | | | | | | | | |
| | | | | 45- E | · Carrol | 157 | 1.,50 | 1.360 | 7, | MD. | | |
| | JAN 24 1996 | 32. REGISTRAR'S SIGN | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / De

| partment of Health and Me | ntal Hygiene | 96 | 0364 |
|---------------------------|--------------|----|------|
| ertificate of Death | Reg. No. | 20 | 0004 |

| Physician |
|-----------|
| |
| /Medical |
| Evaminar |

Funeral Director

with the Maryland 28a-1 show traumetic event, the Medical Examiner must be notified at ò 238 permit. Pages 1 and 2 should be filed within 72 hours efter death value bepartment of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumstic event. the Helical Examples means

Baltimore, Maryland 21215-0020

Box 68760

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Division of Vital Records.

Physician /Medical Examiner

physicien and the buriel-transit thet the death certificate be 80 980 signed I been si pege 2 s certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Š

1. Decedant's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month Vaar ELIZABETH BRINCK JANUARY 27,1996 0130AM 4e. Feclity Nema (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death | COCKEYSVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth | Months | Days | Hours | Min. | Month, Day, 13945 YORK ROAD BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 1□M 2⊠F May 9, Yrs. 20 218-82-5667 Maryland Usuel Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3495 Albantowne Way 21040 Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritel Stetus 14. Race - American Indien, Black, Whita, etc. 1 Naver Married 2 ☐ Married 1 ☐ Yas 2 🔯 No If Yes, Giva Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Yaer or Datas: White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grede complated) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Coilaga (1-4or 5+) 12 Copy Consultant Printing 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) å Christine Ann Marietta Jon Michael Brinck 2 19a. Informant's Name/Ralationship (Typa, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3495 Albantowne Way, Edgewood, Md. 21040 Jon Michael Brinck-Father 20b. Place of Disposition (Nama of cematary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Bel Air Memorial Grdns. 1/30/96 Bel Air, Maryland 22. Nema and Address of Fecility Howard K. McComas III Funeral Home, P.A. Part 1. Enter the Abrasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart future. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Md. Approximata Intarval Betw Head and Nach Cymres Immadiata Causa (Final diseasa or condition resulting In daath) Examine Sequantially list conditions, if eny, laeding to immadiate cause. Enter Undarfying Causa (Disaase or Injury that Initiated avants rasulting in deeth) Last Due to (or as a consequence of) Physician/Medical Dua to (or es e consequance of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ρ 24b. Wera eutopsy findings available prior to completion of cause of daath? 24a. Was an eutopsy performed? Completed Be 25. Was casa rafarred to medical examinar? 26. Piece of Death (Check only one) examinar≀ 1**52**Yes 2∐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Stothar (Specify) AT SCENE Certification: To 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending invastigation drive struckby ject 1 Natural 1 Yas 2 No 1127/16 anotherwhick 2 Accidant 0115 6 Could not be datarmined 3 Suicide 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 13943 Your Road 28a. Piece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida roodway Baltimore Country To the Hospital within 24 hours a To the Funeral Completaly filled edicai 29a. Certifiar 1 Cartifying Physician: To tha best of my knowledga, daath occurred at tha time, date end place, end due to the ceuse(s) and manner as stated. 22 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. 29b. Signetura and titia of cartifier 29c. Licansa numbar 29d. Data signed (Month, Day, Year) U. King NO O.C.M.E. JANUARY 27, 1996 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) HE MORE MIK 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura

Pages 1, 2, 3 should

DIRECTOR

FUNERAL

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans. In some after death with the Cras form of Health and Mental Heritan in Punial mentalion or moneal | IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| FENDING | OR. After | 8 Is may |
| OR ATT | DIRECTO | tem 2 |
| SPITAL | VERAL I | T. II. I |
| TO THE HO | TO THE FU! | IMPORTA |
| | | |

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Biddison January Ethel Lorraine 7. DATE OF BIRTH (Month, Day, Year) NOV. 30, A. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 212-03-9694 1 M 2 X F 83 Maryland 1912 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Fallston General Hospital Fallston Harford RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Bel Air 1 TYES 2 X NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 908 Southampton Rd. 21014 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian Black, White, atc. 1 Never Married 2 Married Specify: 3

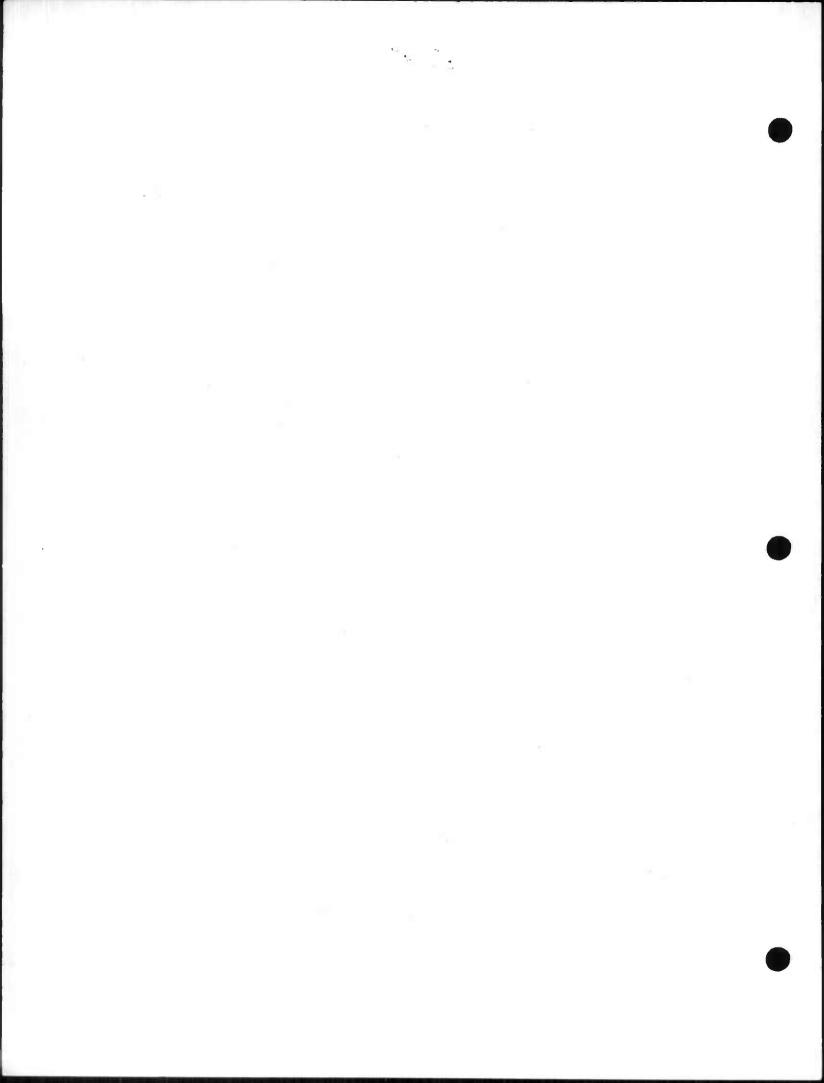
Widowed 4 □ Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 165 KIND OF BUSINESS/INDUSTRY (Specify only highest ive kind of work done
. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Road Construction 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) William н. Price Fanny (nmn) (U/K) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Dudley, Sr. P. O. Box 31, Bel Air, Maryland 21014 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 20a. METHOD OF DISPOSITION

1 X Burlat 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Air Memorial Gardens 2+2-96 Bel Air, Md. 21. SIGNATURE OF FUNE OLL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
HOWARD K. McComas III Funeral Home, P.A. 23. PART I. Effer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. 21009 1317 Cokesbury Rd., Abingdon, Md. Approximate Interval Batween **Onsat and Death** IMMEDIATE CAUSE (Final disease or condition Myocardial Eschemia, Myocardial Enfarction 2 days resulting in death) Pul. vedema, Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF). If any, leading to immediate cause. Enter UNDERLYING 6 weeks Thromboutopenia CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events Portal Hypertension resulting in deeth) LAST 2 Yrs Hyperspleenism, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1) Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26b. TIME DF 28e. DATE OF INJURY 26c. INJURY AT WORK? 284 DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending м 1 YES 2 NO A _ Accident Investigation 26s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suictde 261. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be determined 4 Homicide 29a. CERTIFIER

// CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B Parekh MD D18424 DJan-30-96 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1908 HARFORD RUAD, FALLSTON Parekh MO

32 REGISTRAR'S, SIGNATURE



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| director | | er mus | |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be det | | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| - DA | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | nedica | |
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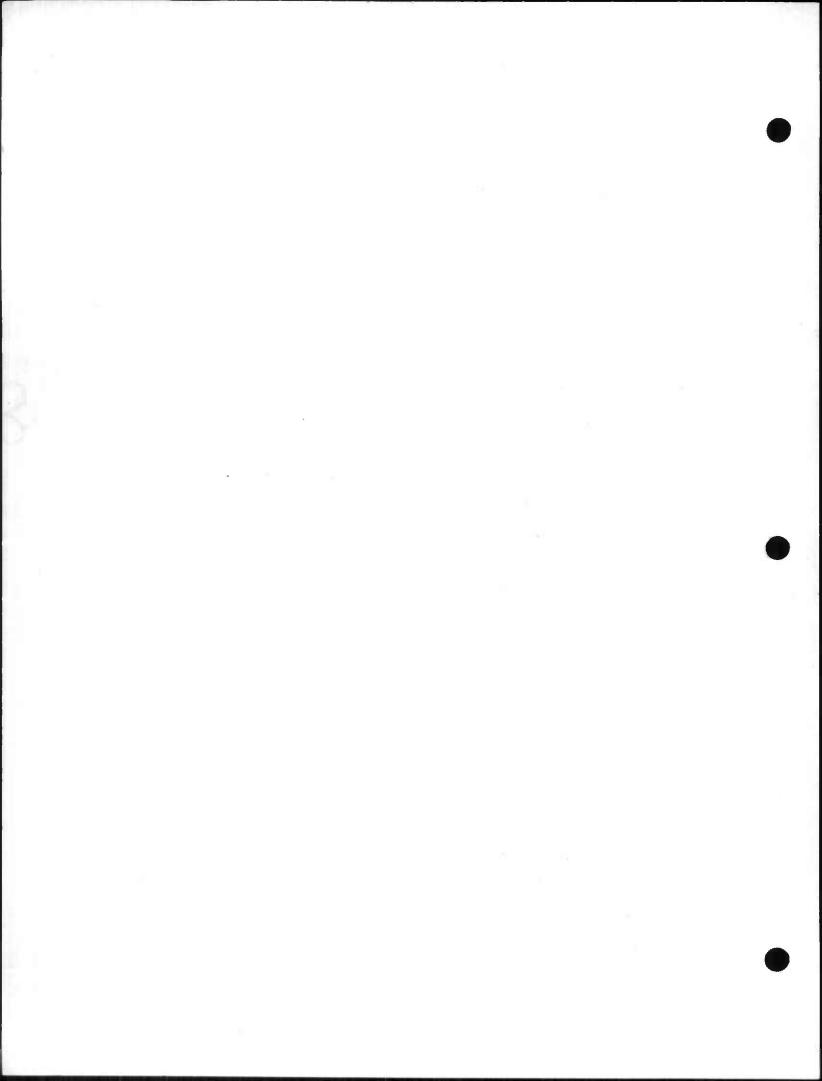
| | FOR 1 - STATE REGISTRAR | STATE OF N | MARYLAND / | | RTMENT OF | | | MENTAL | HYGIEN REG. NO | | 90 | 03648 |
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| - The state of | DECEDENT'S NAME (First, Middle, Lest) | Christ | cina Do | | | | AIII | 2. DATE OF DEATH DAY FEAR FEBRUARY 1, 1996 | | | YEAR 3 | TIME OF DEATH |
| 1000 | 4. SOCIAL SECURITY NUMBER 220-46-9391 98. FACILITY NAME (If not institution, give st | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YEA | AR IF U | | 7. DATE O (Morith, March | F BIRTH Day, Year) | 1908 | 8. BIRTHPL Country) | ace (State or Foreign |
| DIRECTOR | Allegis Health & F | Rehabilit | ehabilitation Ctr. Silver Spring | | | | | EATH | | ту | | |
| | Maryland Monto | omery | | Chevy Chase | | | | 1 | MI YES 2 NO | | | |
| FUNERAL | | FOROGO I | | | | 101. ZIP COOE 20815 R IN U.S. ARMED 13. WAS DECENDENT OF HISPANI | | | | Unit | ed St | American Indian. |
| B⊀ | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | MR OR DATES | | 10 | YES 2 X | NO Specif | y: | | | Specify: Whi | te | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) 2 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 16. KIND OF BUSINESS/INDUST (Dive kind of working life. Do NOT use refired.) OWN Home / Cha | | | | | | | | | ies | | |
| BE CON | | | | | | | | | | | | 200 |
| 0 | Mary Anne Baily | | | 643 | Owl Way | , S | | ta, | FL 3 | 4236 | | |
| | 200. METHOD OF DISPOSITION 1 | | | | | | | | | | | |
| | · Eleen & | U. K | app | | 933 | Gist | Aven | ue, S | ilver | Spri | 0. | D 20910 |
| | interpretation and the condition | | | | | | | | | | Approximate interval Between Onset and Death |
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| _ | PART II. Other significant condition | s contributing to | death but not | resulting | In the under | ying cau | se given in | Part I. | 24a. WAS AMPERFO | RMED? | C | VERE AUTOPSY FINDINGS VAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES XX NO |
| IAN: N | DID TOBACCO USE CONTI | | | | ES NO | , · | NCERTAI | N 🗆 | | | | |
| BY PHYSICIAN: MEDICA | EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 26e. DATE OF (Month, D | INJURY | 28b. TII | JURY | Home 5 NJURY / WORK? | AT | | | INJURY OCC | CURED | |
| | a County — 1 288, PLACE OF INJURY — At home form street factory office 1 284 1 OCATION (Street and Number of Burn) Bouts N | | | | | | | | | ite Number, | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | and menner ee stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CONTINER 296. LICENSE NUMBER D09834 29d. DATE SIGNED (Month, Day, Year) February 1, 1996 | | | | | | | | | | | |

Barry N. Rosenbaum, M. D., 3720 Farragut Avenue,

31. DATE FILEO (Month, Day, Year)

EB 02 1996

Kensington, MD 20895



Please Type or Print in Black Indelible Ink. Assure All Copies Are Logible State of Maryland / Department of Health and Mental Hygiene 96 03649

| | | | A Basedont News (Free 1474) | Cont. | | Cer | tificate of | Death | | g. No. | | |
|--|--|----------------|--|---|-----------------------------------|--|---|---|---|--------------------------------|------------------------------------|---|
| | Physic | ian | 1. Decedent's Name (First, Middle, Le | | D | | | | 2. Dete of Death | Day | Year | 3. Time of Death |
| | /Medi | | EILEEN | Duva11 | | ma | UIST | | Sanua | | | 8 COSTAL |
| | Exami | ner | 4a. Facility Name (If not institution, gin Suburban Hospita | |) | | | 4b. City, Town, or Bethesda | Location of Death | 4c. County Mon | of Deeth atgomer | y |
| | Funeral Director | | 494-12-7630 | Sex 7. A 1 □ M 2 □ ÅF | ge (In yrs. last b | birthday) Yrs. | If Under 1 Year Months Days | | | ^{Year)} 1918 | 9. Birthplac Country, Oklaho | a (State or Foreign)))ma |
| | pu . | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | um ar l a | nation | | | | 101 | 1-14-00-11-1 |
| | sho | 2 | Maryland Montgon | nerv | | | hase | | | | 100. | . Inside City Limits 1 XYes 2 No |
| | The N | Director | 10e. Street end Number | ile Ly | One | - | 1 | | | 0111 - 111 | | |
| | with or | ā | | | | | 10f. Zip Code | - | 10 | | What Country | 7 |
| | eath m 23 | era | 3510 Taylor Stree | 12. Wes Deceden | Ever in U.S. | 12 V | 2081. | | Specify Vec or No. | U.S.A | e - American | Indian |
| 020 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show hit, the Medical Examination notified at | by Funeral | 1 Never Married 2 Merried 3 Widowed 4 Divorced | Armed Forces 1 Yes 2 tf Yes, Give Year or Dates: | ? ENo | er in U,S. 13. Was Decedent of Hispenic Origin? (Sit Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify: | | | to Rican, etc.) | | ck, White, etc | |
| 5-0 | 5-0 72 ho | Completed | 15. Decedent's E (Specify only highest gr | ducation | 16 | a. Deced | ent's Uauel Occu | pation | 1. | 8b. Kind of B | usiness/Indus | itry |
| 21 | d 21215-0020 filed within 72 hours af Hygiens ther than "natural", or mt, the Made el Exam | | Elementary/Secondary (0-12) | College (1-4or | 5+) | life. D | O NOT use retire | during most of wo | , Kuig | | | |
| | | | | 2 | re | eal e | state a | 1 | | | estate |) |
| tal H doth | | Be | 17. Father's Name (First, Middle, Last | " | | | | 11.000000000000000000000000000000000000 | me (First, Middle, M | | ne) | |
| Baltimore, Maryland 21215-0020 Jean Pages 1 and 2 should be filed within 72 hours after death with the Marylar Decembert of Heelth and Mental Hygiene. The principle of Heelth and Mental Hygiene. The principle of the real page of the marked of the Medical Examiner must be notified as not the marked. | J Mental | To | Clay Duvall | | | | Link School Co. | | beth Wall | _ | 2000 - 2 | |
| | d2 st th and 7 is n | | Jill Filipczyk (daughter) 19b. Mailing Address (Stre | | | | | | | | | xde) |
| | Heelt Heelt Pm 2 | | Jill Filipczyk 20a. Method of Disposition | (daugnter | | | ition (Name of | st., they | | | City or Town | State |
| | 00- | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | | cemet | tery, crem | etory or other pla | | Jan. 22,96 | | | |
| | ermit. Nepartr mporta ny inju | | 21. Signature of Funeral Service Lice | nsee O | 1 | 22. | Name end Addr | | | | | |
| _ 402.0 | | Ш | ames it | 3 1/04 | | | 2222 Wi | sconsin A | Ave. N.W. | Wash., | DC 200 | 007 |
| The same | | | 23a Part1. Enter the disease, or com- abook, or heart tailure. List only | plications that chuse one cause on each | d the deeth. Do | o not ente | er the mode of dy | ing, such es cardie | c or respiretory erres | st, | In | pproximate terval Between |
| | Physician | D.C | | | | | | | | | O | nset end Death |
| | /Medical Examiner | | Immediate Cause (Final disease or condition resulting in deeth) a. Due to (or as e consequence ot): | | | | | | | | | WEEK |
| в | | 10 | | | | | | | | | | |
| | ted nsit | F | | b | HEM | IP. | LEG | IA | | | de | NEEKS |
| -6 | ificata be executed g physician and as the buriel-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence ot): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | 1 4 - 1/ / |
| 68760, | sicial | | Cause (Disease or Injury that initieted events | c. LEF | [] [] [] | 1846 | ERE | BRAL TX | TERY [HROMBOSIS & WEEKS | | | |
| 68 | ificati g phy as th | edical | resulting in death) Lest | 1 | Due to (or as a | mercial. | 60 | | | | 1 | Duran |
| Box | | Physician/M | | d. DENE | RALI | ZEL | 1+6 | HEROS | CLEROSL | <u></u> | X | DYEARS |
| | the atte | sicia | Part II. Other eignitteant conditions of | contributing to death i | out not resulting | in the un | deriving cause gi | ven in Part I. | 23b. Did tob | acco use co | ntribute to th | ne cause of death? |
| P.0 | that the de ed by the detached | hy | 1.1 | | | | | | . 1 Ye | 2 No | 3 Probab | oly 4 Unknown |
| | signed I | by F | TIYFER (EN- | 510N; | LEL | L-01 | -1715 | LEGS | | /\ | | |
| of Vital Records, | requ | Completed | LYMPH EDEN | MA, LEU | FS; | DIA | ABETEC | | 24a. Was an perform | | evalia | autopsy tindings able prior to eletion of cause |
| Re | dclan: The lew certificata hes b rector, page 2 s | ошо | Maria | | | | | | 1 ☐ Yes | 200 No | of dea | es 2□No |
| ta | ysician: The le is certificata he director, page | Bec | 25. Was case reterred to medical | | | | | 28. Place of De | eth (Check only one | | | |
| > | Physician: r this certific real director, | ToB | examiner? 1 Yes 2 No | Hospital: | ient 2 ER/C | Outpetient | 3□ DOA Ot | har | Home 5 ☐ Residen | | ner (Specify) | |
| | F = E | | 27. Manner of Death | 28a. Date of fnj (Month, De | ury 28b | . Time of Injury | 28c. Inju | iry at | 28d. Describe how | w Injury occur | red | |
| io | ath. r: Af | atic | 1 Natural 5 Pending 2 Accident Investigation | n | -, | nijai y | | Yes 2 No | | | | |
| Division | I or Attending I after death. Director: After d in by the funer | Certification: | 3 Suicide 8 Could not be determined | 28e. Place of in | ijury - At home, tc. (Specify) | tarm, stre | et, factory, office | | 28f. Location (Stre City or Town, | | ber or Rural R | oute Number, |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | edical C | 29a. Certifier (Check only one) Cartifying Pr 2 Medical Exer | nysician: To the best niner: On the bests of end menner s | ot examination a | ge, death and/or inv | occurred at the ti estigation, in my | ime, date and place opinion, deeth occ | e, and due to the cat urred at the time, dat | use(s) and ma te and placa, | anner as state and due to th | ed. e cause(s) |
| | To the To the comp | M | 29b. Signature and title of centrer | 1/2 | $\sim m$ | 0 | 29c. Licen | se number | 7 (29 | d. Dete signe | d (Month, De | y, Year) |
| | | | Joseph 1 | anne | 11/1/11 | // | 1)-0 | 1204 | 1 | n.18 | 119 | 76 |
| | | | 30. Name and address of person who | 11 | | | - | BETT | HESOA, WAL | 1020 | 814-1 | 729 |
| | | | 31. Date tiled (Month, Day, Year) | NNOR M | rar's Signature | 420 | OLD (| -EUR-E | 1000N | ROA | D | |
| | Sta Registr | | JAN 3 0 1 | | Awdion | P . | | | | | | |
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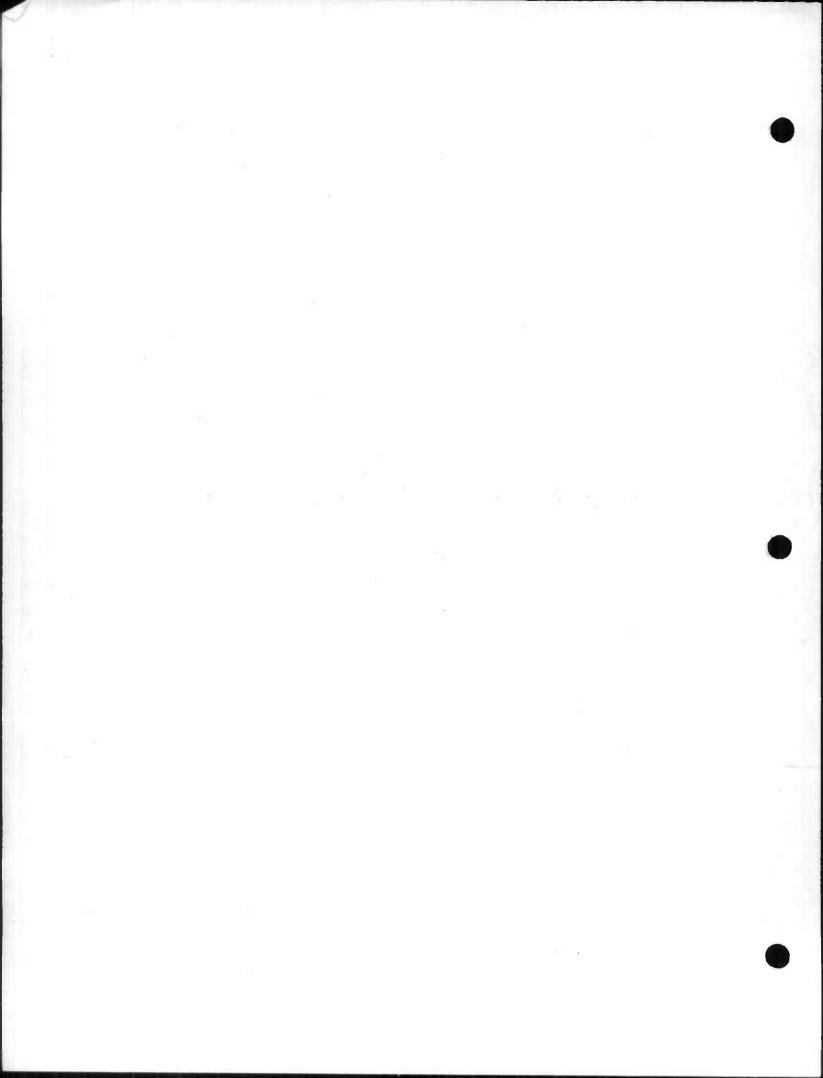
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. |
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| TO THE HOSPITAL DR ATTENDING PH | TO THE FUNERAL DIRECTOR: After th | be filed within 72 hours after death w | IMPORTANT: If item 28 is mark |

| BEOGRAPHO HAME OF LANCE | | CE | ERTIF | ICATE OF | DEATH | | REG. NO. | | | A = 1110 A = |
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| DECEDENT'S HAME (First, Middle, Last) | 1. | 0.1 | 07 | -001 | | 2. DATE OF | DA | | YEAR | 3. TIME OF DEATH |
| WILLIAM | H | | | NO | | JAI | | 619 | 996 | 11:35 |
| SOCIAL SECURITY HUMBER | | i. AGE (In yrs. las | | MONTHS DAYS | IF UNDER 24 HRS. | 7. DATE OF (Month, I | Day, Year) | | Countr | |
| 233-42-0746 | 1 🔀 M 2 🗌 F | 66 | YRS. | | | Apr. | 22, | 1929 | Wes | t Virginia |
| e. FACILITY NAME (If not institution, give : | street end number) | | | 96. CITY, TOWN | OR LOCATION OF DE | EATH | | 9c. COU | HTY OF D | EATH |
| Holy Cross Hosp | pital | Silver Spring | | | | | | Mor | ntgom | nery |
| RESIDENCE OF DECEDENT 104. STATE 10b. COUNT | | | I an orr | Y, TOWN OR LOCA | rion: | | | | | tod. INSIDE CITY |
| | | | 100. 011 | Bethesd | | | | | | LIMITS? |
| | ntgomery | | 1 | | | | | 1 | | 1 YES 2 NO |
| 00. STREET AND NUMBER | | | 101. ZIP CODE 20814 | | | | | | ZEH OF WHAT COUNTRY? | |
| 7001 Exfair Road | | | | | | | | | States | |
| 1. MARITAL STATUS | YES 2 1 | | | | | | or Ho— | 14. RACE Black | E — American Indian, k, White, etc. | |
| Never Married 2 Married Midowed 4 □ Divorced | IF YES, GIVE WA | R OR DATES | | 1 TYES | 2 HO Specify | city: | | | | My: |
| | 1 1947 - | | | | | 1 | | | | White |
| 15. DECEDENT'S EDU (Specify only highest grade | | (G | CEDENT'S live kind of a Do NOT us | VSUAL OCCUPATI work done during m | ost of working | | ind of sui | | DUSTRY | |
| Elementery/Secondary (0-12) | | | | tor | | _ | | anac | ortation | |
| 12 | | Equ | тЪше | nt Opera | | _ | | | ansp | ortation |
| 7. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S HA | | | Sumame) | | |
| Jesse Bryant Bu | rton | | | | Carrie | Sutpi | 1111 | | | |
| 9e. INFORMANT'S NAME (Type/Print) | | | | | and Number or Rural | | | - | | 0011 |
| Helen L. Burton | | | 7001 | Extair | Road, Be | | i, Ma | rylai | nd Z | 20814 |
| toe. METHOD OF DISPOSITION | movel from State | 20b. PLACE | AND DATE | of DISPOSITION (Nother place) | n 27 . 10 | 996DATE | 20c. LO | CATION - | City or To | own, State |
| ☐ Donetion 8 ☐ Other (Specify) | noval nom grand | Mont | gomei | y Crema | torium, | Ínc. | Be | thes | da, M | Maryland |
| H. SIGNATURE OF FUHERAL SERVICE LI | ICENSEE | | | 22. NAME A | nd address of fa | CILITY | Fune | ral I | Home / | / |
| 1/2 | m. 1 | M00 | 198 | | Bethesda: | -Chevy | 7 Cha | se. | Inc. | |
| 23. PART L Enter the diseases, or | complications that | nounced the de | odb Do | 17557 | Wisconsi | n Ave. | , Bet | nesda | a,MD | 20814-350 Approximete |
| shock, or heart failure. | | | | not ether the m | rae or aying, suc | AT AS COTOR | rc or resp | iraiory e | 1001, | Interval Betw |
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| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (6 | DR AS A CONSE | OUENCE O | ia. Pill C | aucei | L | ing | Alivasev | | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO (6 | DR AS A CONSE | OUENCE O | ia. Pill C | aucei | Part I. | L WAS AN PERFO | | 7 24t | o. WERE AUTOPSY FIND AMILABLE PRIOR TO |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (6 | DR AS A CONSE | OUENCE O | ia. Pill C | aucei | | | RMED? | 7 24b | o. WERE AUTOPSY FIND AMILABLE PRIOR TO |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (C | OR AS A CONSE | OUENCE O | P: 2 C | QU CLI | | PERFO | RMED? | 7 24t | o. WERE AUTOPSY FIND AMRIABLE PRIOR TO COMPLETION DF CAU |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (C | OR AS A CONSE | OUENCE O | in the underlyle | g cause given in | | PERFO | RMED? | 246 | o. WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (0 | OR AS A CONSE | OUENCE O | Fi: In the underlying ES NO [TH (Check only one | g cause given in | | PERFO | RMED? | 246 | MAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONTES. WAS CASE REFERRED TO MEDICAL | b. DUE TO (C | OR AS A CONSE | OUENCE O CI OUENCE O reaulting | In the underlyle ES NO [TH (Check only one OTHER: | g cause given in | N 🗆 | PERFO | RMED? | 7 24t | o. WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONTEXT WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 (THO) 27. MAHHER OF DEATH | DUE TO (C | DR AS A CONSE | OUENCE O OUENCE O reaulting ATH YI CE OF DEA | F): In the underlyle ES NO [TH (Check only one OTHER: 4 Hursing Ho AE OF 28c. IN | g cause given in | N D | PERFO | RMED? | | MAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONTEST WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 CHO 27. MAHHER OF DEATH 1 Netural 8 Pending | DUE TO (6 d. TRIBUTE TO CAL HOSPITAL: 1 X Inpetient 2 28e. DATE OF I | DR AS A CONSE | OUENCE O OUENCE O reaulting ATH YI CE OF DEA | In the underlyle ES NO [TH (Check only one OTHER: 4 Hursing Ho AE OF 28c. IV. | g cause given in UNCERTAI | N D | PERFOI | RMED? | | were autopsy finds mailable prior to completion of caus of death? |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONTEST OF THE CAMERICAL EXAMINER? 1 YES 2 CHO 27. MAHHER OF DEATH 1 Natural 8 Pending | DUE TO (C. STY) DUE TO | DR AS A CONSE | OUENCE O CU OUENCE O reaulting ATH YI CE OF DEA 3 □ DOA 28b. TH | In the underlyle ES NO [TH (Check only one OTHER: 4 Hursing Ho AE OF 28c. IV. | UNCERTAL DO NO | 8 Other | PERFOI YES: (Specify) RIBE HOW | INJURY ON | CCURED | o. WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONTEST WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 CHO 27. MAHHER OF DEATH 1 Netural 8 Pending Investigation | DUE TO (C. STY) DUE TO | DR AS A CONSE | OUENCE O CU OUENCE O reaulting ATH YI CE OF DEA 3 □ DOA 28b. TH | F): In the underlying ES NO [TH (Check only one OTHER: 4 Hursing Ho AE OF JURY M 1 | UNCERTAL DO NO | 8 Other | PERFOI 1 YES : | INJURY ON | CCURED | b. WERE AUTOPSY FINDS AMALABLE PRIOR TO COMPLETION DF CAU OF DEATH? t YES 2 NO |
| PART II. Other significent condition Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 CHO 27. MAHHER OF DEATH 1 Netural 8 Pending investigation 3 Suicide 6 Could not be determined | DUE TO (C. | DR AS A CONSE JOR AS A CONSE | OUENCE O COUENCE O reaulting ATH YI CE OF DEA 3 DOA 28b. Thi IN | In the underlyle ES NO [TH (Check only one OTHER: 4 Hursing Ho BE OF 28c. Ik JURY M 1 street, factory, offi | QUICLI Ig cause given in UNCERTAI Inne 8 Residenca UNRY AT ORK? YES 2 NO | 8 Other 28d. DESC 28t. LOCA | PERFOI 1 YES : (Specify) RIBE HOW | INJURY O | CCURED er or Rurel | b. WERE AUTOPSY FINDS AMALABLE PRIOR TO COMPLETION DF CAU OF DEATH? t YES 2 NO |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONTEST OF THE CONTES | DUE TO (C. STY) DUE TO | DR AS A CONSE JOR AS A CONSE | OUENCE O OUENCE O reaulting ATH YI CE OF DEA 3 DOA 28b. Till 8N ome, ferm, | In the underlyle ES NO [TH (Check only one OTHER: 4 Hursing Ho HE OF JURY M 1 street, factory, offi | g cause given in UNCERTAI DIVENTATION THE S PRESIDENCE SURPY AT ORK? YES 2 NO THE STATE OF THE STATE O | 8 Other 28d. DESC 28t. LOCA City or | PERFOI Specify) RIBE HOW FION (Street Town, State Ge) end ma | INJURY ON and Numbinner ea at | CCURED or or Rural ated, | D. WERE AUTOPSY FINDS AMBLABLE PRIOR TO COMPLETION DF CAU OF DEATH? 1 YES 2 NO Route Number, |

ANURITA MENDHIRATTA
31. DATE FILED (Month, Day, Your)

JAN 30 1996

JAN 30 1996



State of Maryland / Department of Health and Mental Hygien

96 03651

| | | | | | | Ce | rtificate | of De | eath | | Reg. N | lo. | | | | |
|---|--|----------------|---|---|----------------------------------|------------------------------|----------------------------------|--------------------------------|---------------------------------|----------------------------|---------------------|-------------------------------------|---------------------------|--|-----------------------------------|--|
| 1 | | | Decedent's Name (First, Middle, Last |) | | | | | | 2. Date of I | | | | 3. Tirr | e of Death | |
| | Physic /Mod | | JACOB HICKS BA | JAN. | | 6. 19 | Year OG6 | 5.5 | 5 P.M. | | | | | | | |
| 0 | /Medi Exami | | As Facility Name (March Individual) | | | | | | | | | | y of Death | 10.0 | J 1.H. | |
| -11 | Exami | 1161 | COLLINGTON EPIS | | | E COM | MIINITTY | I MO | TTCUET | LVILLE | | | E GEO | DCE | | |
| Н | Francis | | 5. Social Security Number 6. Se | | Age (In yrs. I | | | | f Under 24 Hr | | | | - | | No or Fornia | |
| | Funeral Director | | | | 90 | Yrs. | | | Houra Mi | | | | WASH | INGT | ON, D | |
| | within 72 hours aftar death with the Maryland ena. than "naturet, or items 23s or 28s-f show he Modrell Exactive must be notified at | Director | 10a. State 10b. County MARYLAND PRINCE | GEORGE | | Town or Le | | | | | | | 1 | | le City Limita | |
| | # 22 # | ire. | 10e. Street and Number | | | | 10f. Zip Co | de | | | 10g. C | itizen of | What Cour | ntry? | | |
| | 13 wi | JE C | 10450 LOTTSFORD RO | DAD | | | 20721 | | | | U.S. | Α. | | | | |
| | deat | Funeral | 11. Marital Status | 12. Was Deceder | | | Was Decedent | of Hispa | anic Origin? (| Specify Yes or I | | 14. Rac | ca - Americ | | n, | |
| 21215-0020 | urs aftar el', or its | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Force 1 Yes 2 [It Yes, Give Year or Date: | □No | | 1 ☐ Yes 2 🔀 | | Mexican, Pue Specify: | uèrto Rican, etc.) | | | ck, White, y: WHI | | | |
| 9 | 2 ho | Completed | 15. Decedent's Edu | cation | | 16a. Dece | dent's Usual O | | 16b. Kind of Busines | | | | | | | |
| 215 | 7 11 1 | ple | (Specify only highest grad Elementery/Secondary (0-12) | | - 5.) | (Give life. | kind of work do DO NOT use re | one duri etired) | ing most of w | orking | | | | , | | |
| 21 | many rate and the same | E | Liementery/Secondary (0-12) | College (1-4o | 11 3+) | AGEN | т | | | | LTI | E T | NSURA | NCE | | |
| D | filed Hygie offer | Bec | 17. Father's Name (First, Middle, Last) | | | 1101311 | | 18 | B. Mother's No | ame (First, Midd | | | | NOL | | |
| Maryland | aryland 212. should be filed within and Mental Hygiena. marked other than umatic event, the Mental Control of the Control of t | | ALBERT BALDWIN | | | | | J | DSEPHI | NE HUI | TLE | Y | | | | |
| | od 2 in a rate of rate | | 19a. Informant's Name/Relationship (Ty SHIRLEY COLL, DAUG | | | | POTOMAC | | | | Code) | | | | | |
| Baltimore, | permit. Pages 1 and: Department of Health Important: If Item 27 any injury or other tr | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F | lemoval from Stat | 0.0 | ace of Dispo metery, cre | osition (Neme o | of plece) | | Date | 20c. | 20c. Location - City or Town, State | | | | |
| E | Pant: | | 4 Donetion 5 ☐ Other (Specify) | | 1000 | LINC | OLN CEM | ETE | RY | 1/31 | BRI | ENTW(| 00D, | MD. | | |
| Baltimol permit. Pages Department of important: If it any injury or o | | | 21. Signature of Funeral Service License | 99 | Λ | 22 | 2. Nama and A | ddress c | of Facility | ONC THE | | 120 1 | JT A | WE | NI LY | |
| Ш | 80 5 5 8 | | 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility JOSEPH GAWLER'S SONS, INC 5130 WI. AVE. N.W. WASHINGTON, D.C. 20016 | | | | | | | | | | | | | |
| | Physician | | 23a. Part1. Enter the disease, or complishock, or heart tailure. List only or | cationa that caus ne cause on each | ed the death line. | | | | | | arrest, | | 1 | Onset a | Between and Death | |
| ı | /Medical Examiner | П | Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequenca ot): Neuroleum De mo | | | | | | | | | | | | | |
| | | je. | Due to (or es a consequenca ot): Neuro 1812 Dyulkof C | | | | | | | | | | | | 4600 | |
| | uted d ansit | Examiner | | | | | | | | | | | | 9 | | |
| o, | axec n an lal-tr | EX | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c. | | | | | | | | 1 | | | | | |
| 68760, | sertificate be axecuted ding physician and se as tha burial-transit | | Ceuse (Disease or Injury that initiated events | For the course was a | | | | | | | _ | * | | | | |
| 89 | fication phy | Medical | resulting in death) Last | Due to (or as a consequence of): | | | | | | | | | | | | |
| × | certific ding p | | | d | | | | | | | | | | | | |
| Bo | death of attended for un | Physician | | | | | | | | | | | - ! | | | |
| o | 2 2 | ysi | Part It. Other significant conditions con | tributing to death | but not resu | ting in the u | nderlying cause | e given i | n Part I. | 23b. DI | d tobacc | o use co | ptribute to | the cau | se of death | |
| P.0 | that the de ed by the a detached | | Consulive | Hear | 7 7 c | nul. | e e | | | 10 | Yes | 2 No | 3 Prof | bably | Unknow | |
| S, | signed be de | þ | | | | | | | | | | | Tarren | | | |
| of Vital Records, | law requires that the as been signed by th t 2 should be detache | Completed | | | | | | | | 24a. We | s an aut formed? | opsy | av | ere autop railable pr mpletion death? | sy findings for to of cause | |
| al B | The ate h | | | | | | | | | 10 | Yes : | 2 No | 10 | Yes | 2□ No | |
| Ę. | Physiclan: r this certific inal director, | Be | 25. Was case reterred to medical examiner? | la a a léa l | | | | | B. Place of De | eth (Check only | one) | | | | | |
| 5 | Physi this c | ဥ | TE TOS XX | 1 | tient 2 E | R/Outpatier | | | 4 | Home 5□Re | sidenca | 8 DOth | er (Specif | у) | | |
| ion | ing Afte fune | ation: | 27. Menner of Death 1 Natural 2 Accident 5 Pending investigation | 28a. Date of In (Month, D | jury Jay Year) | 28b. Time o injury | | Injury at Work? 1 ☐ Yes | 2 □ No | 28d. Describe | e how inj | ury occur | red | | | |
| Division | | Certification: | 3 Suicide 8 Could not be 4 Homicide determined | 28e. Piaca of I building, o | njury - At hor etc. (Specify) | ne, farm, str | eet, tectory, off | Ice | | 28f. Location City or T | (Street a | ind Numb te) | ber or Rura | Il Route I | Vum <i>ber</i> , | |
| | Hospita 24 hours Funeral staly fille | edical C | 29a. Certifler (Check only one) 1 Certifying Phys 2 Medical Examir | er: On the basis | ot examinati | iedge, deett on and/or In | n occurred at th | e time, o | date and place on, death occ | e, and due to the | e cause(| s) end ma | anner as si and due to | tated. | se(s) | |
| | To the within 2 To the comple | - | 0.00 | and manner s | stated. | | | | | | | | | | | |
| | O T W T | | 30. Name and address of person who co | -/1 | Attend | 7 | 290. Lio | ense nu | 77 | | 29d. D | 29 | d (Month, | <i>∪</i> ey, Yea | ar) | |
| | | | 30. Name and address of person who co | mpleted cause of | death (Item | 23a) (Type, | Print) | e | Place | × ,/e, | اردمه | L. 1 | no 2 | 2070 | C | |
| | | | 2 -11 (-1) [0/4 (18) | | / [7 | - 1 E | * K - good ! | | , | 1 | | | | | | |

31. Date tiled (Month, Dey, Year)

JAN 3 0 1996

32. Registrar's Signeture

Registrar

ALLECT TEACH. dollar Color Retroit B The column is \$150

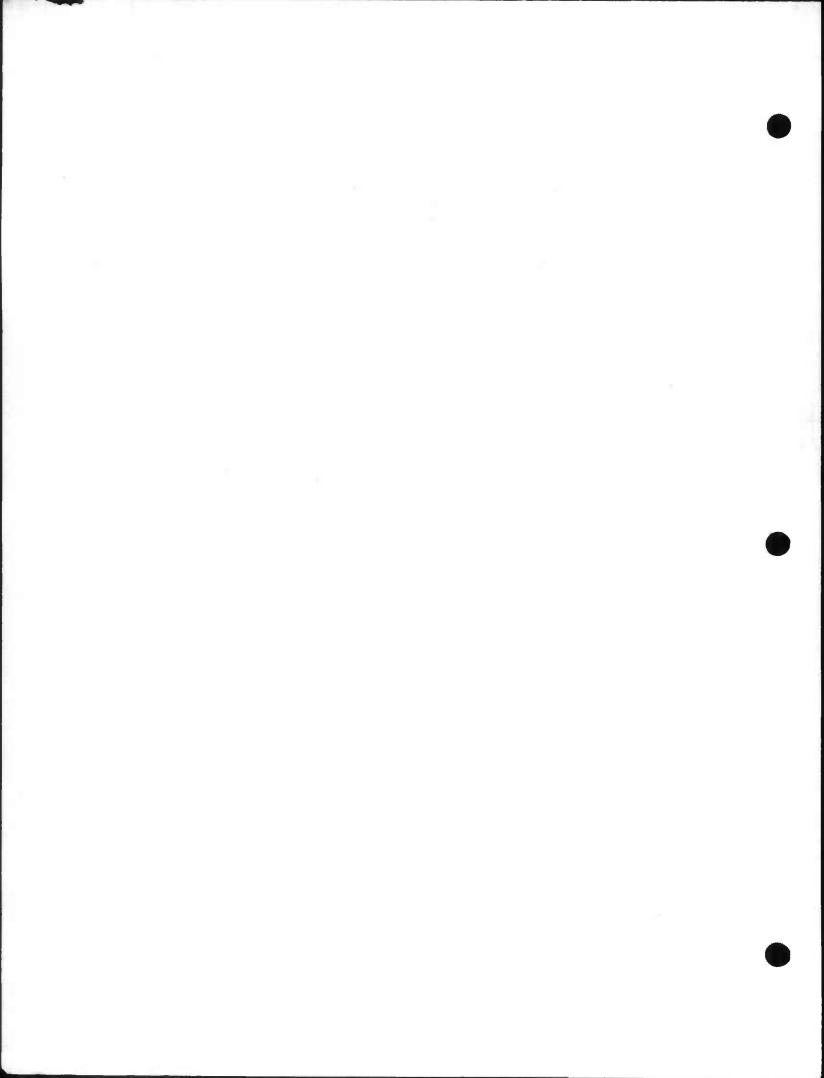
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYLA | | TMENT OF I | | | ILENE NO. | | | | | | | |
|------------------|--|---|---------------------|--------------------|---|------------------------------------|---------------------|------------------|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEA | тн | | 3. TIME OF DEATH | | | | | |
| - 8 | | illard | Bishop | | | January | | YEAR | 9112 A # | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | yrs. last birthday) | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRT (Month, Day, Yo | suc) | Country | PLACE (State or Foreign | | | | | |
| | 226 50 2663 9e. FACILITY NAME (If not institution, give str | | 7 YAS. | | OR LOCATION OF DE | April l | 0,1938 | NTY OF DE | Virginia | | | | | |
| DIRECTOR | Shady Grove Adver | | 1 | · | ville | | | ntgo | | | | | | |
| <u> </u> | 10e, STATE 10b, COUNTY | | 10c, CITY | . TOWN OR LOCA | TION | | | 1 | 10d. INSIDE CITY | | | | | |
| Ä | Maryland Montgo | omery | | ithersb | | | | | LIMITS? | | | | | |
| | 10e. STREET AND NUMBER | JileTy | l Ga. | | r. ZIP CODE | | 10- CITI | ZEN OF W | 1X YES 2 NO | | | | | |
| RA | | Land | | - | 201-12-5 | | | | | | | | | |
| FUNERAL | 110 Harmony Hall I | 12. WAS DECEDENT EVER IN | 110 101150 | 40 444 0 00 | 20877 | | | | States | | | | | |
| | 1 Never Merried 2 Merried | FORCES? 1 YES | 2 X NO | If yes, s | CENDENT OF HISPAI ecity Cuben, Mexica | n, Puerlo Ricen, et | | Black | American indien, White, etc. | | | | | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 🗌 YE | 2 NO Specif | у. | | Specifi Not 1 | Hispanic | | | | | |
| | 15. DECEDENT'S EDUC | ATION | 16e, DECEDENT'S | USUAL OCCUPATI | ON | 16h KIND C | F BUSINESS/IND | | iropanie | | | | | |
| ΕI | (Specify only highest grade of Elementary/Secondary (0-12) | | (Give kind of w | vork done durina m | ost of working | | | | | | | | | |
| P | 1 2 | College (1-4 or 5+) | Manage | r | | Bui | lding S | ervi | ces | | | | | |
| COMPLETED | 17, FATHER'S NAME (First, Middle, Lest) | | 8 | | 16. MOTHER'S NA | ME (First, Middle, N | | | | | | | | |
| | Loyd Bishop | | | | | I. Jones | andor ournerney | | | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | and Number or Rural | | or France State Zin | Code) | | | | | | |
| 2 | Shirley Anne Bisho | on | | | Hall Road | | | | 20877 | | | | | |
| | | | | | | | | | | | | | | |
| - 8 | 20c. METHOD OF DISPOSITION 1 & Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Cametery, Crematory or other place) Parklawn Memorial Park 20c. LOCATION — City or Town, State Rockville, Maryland | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE A. Pumphrey Funeral | | | | | | | | | | | | | |
| | Home/Rockville, Inc. 300 West Montgo Avenue, Rockville, Maryland 20850-28 | | | | | | | | | | | | | |
| 1.0 | Many /s | / Non MOC |)689 | Avenue | , Rockvi | lle, Ma | ryland | 20850 | 0-2805 | | | | | |
| | 23. PART I, anter the diseases, or contact or heart fallure. L | omplications that caused list Dnly one cause on ea | the death. Do n | ot enter the m | ode of dying, auc | h as cardiac or | reapiratory arr | real, | Approximate Interval Between | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | | | |
| | disease or condition resulting in death) a. qustrointes that bleeching | | | | | | | | | | | | | |
| | , | DUE TO (OR AS A | 7): | | | | | | | | | | | |
| Z | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| E | | | | | | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | | | | | | | | | | | | | |
| 불 | that Initiated events resulting in death) LAST | | | | | | | | | | | | | |
| CERTIFICATION | | i | | | _ | | | | + | | | | | |
| AL C | PART II. Other algnificant conditions | contributing to death bu | it not resulting I | n the underlyin | g cause given in | | AS AN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS | | | | | |
| | Mabetes | | | | | | ERFORMED? | | AVAILABLE PRIOR TO COMPLETION DF CAUSE | | | | | |
| | | | | | | '''' | ES 2 MU | | OF DEATH? | | | | | |
| Σ | DID TOBACCO USE CONTR | RIBLITE TO CALISE OF | F DEATH YE | S II NO I | UNCERTAI | N DE | | | 1 TYES 2 NO | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | 6. PLACE OF DEAT | | | - 124 | | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: | | OTHER: | ne 5 🗆 Residence | a Out 10- | 5-11 | | ***** | | | | | |
| ΗX | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 26b, TIM | | JURY AT | | y) How injury oc | CURED | | | | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | | URY W | YES 2 NO | | | 001125 | | | | | | |
| BY | 2 Accident Investigation 3 Suicide & Could not be | 28a. PLACE OF INJURY | — At home, term, s | | | 26f. LOCATION (| Street and Number | or Aural A | nute Number | | | | | |
| | 4 Homicide 6 Could not be | building, atc. (Speci | (fy) | | | City or Town, | | | | | | | | |
| <u>-</u> | 29a. CERTIFIER | | | | | | | Hillari | | | | | | |
| COMPLETED | (Check only | CIAN: To the best of my knowle | | | | | | | and manages as 12 at 12 | | | | | |
| 8 | 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end m | | | | | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | A | | | 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, No. D41612. | | | | | | | | | |
| 6 | \ MA | JMD | | | 041612 | | PJA | 1/28/ | 1796 | | | | | |
| | 30. NAME AND ADDRESS OF PERSON THIC | | | | | 0 | | Δ. | | | | | | |
| | Servin Gant Ma 14816 Physicians Lane Suite 253 Rockville, Maryland 20850 | | | | | | | | | | | | | |
| | JAN 31 1996 Julia Davidson-Rardall | | | | | | | | | | | | | |



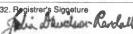


Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene OC

| | | | | | | | tificate c | | | | | 0 1 | 13653 | | |
|------------|---|---|---|---|--|--------------------------------|-------------------------------------|----------------------------|----------------|--|--|---------------------------|--|--|--|
| | Physic | ian | Decedent's Neme (First, Middle, | Last) | | | | | | 2. Dete of Dee Month | th Dey | Yeer | 3. Time of Death | | |
| d | /Medi | | JOHN JOSEPH | BRADLEY | | | | | | | | 96 | 9:22 P.M. | | |
| | Exami | ner | 4a. Facility Neme (If not institution, | | ") | | | 4b. City, | Town, or Loc | ation of Deeth | 4c. County | of Death | | | |
| | . 41. | | 1512 LEMONTREE | | | | | | ER SPR | | Reg. No. eeth Dey Yeer 27, 1996 9:22 P.M. th 4c. County of Death MONTGOMERY irth By, Year) 9. Birthplace (State or Foreign Country) NEW YORK 10d. Inside City Limits TY Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Bleck, White, etc. Specify: WHITE 16b. Kind of Business/Industry ARMY a. Meiden Surname) CUFF Der, City or Town, Stete, Zip Code) KY. 40601 20c. Location - City or Town, Stete ARLINGTON, VA. 3. Time of Death 9:22 P.M. 10d. Inside City Limits TY Yes 2 No 10d. Inside City | | | | |
| 1 | Funeral Director | | 5. Social Security Number 444-15-1207 Usuel Residence of Decedent | 6. Sex 7. A XXM 2□ F | ge (In yrs. Ia | ast birthdey) Yrs. | If Under 1 Ye Months De | | | B. Defe of Birth (Month, Dey MAY 10, | | | | | |
| | hand w | | 10a. Stefe 10b. County | | 10c. City | , Town or Lo | cation | | | | | 11 | 0d. Inside City Limits | | |
| | h the Marylan r 28a-f show | ğ | MARYLAND MONTGO | MERY | SILV | ER SPI | RING | | | | | | Yes 2 No | | |
| | 1 the | Se l | 10e. Street end Number | | | | 10f. Zip Cod | 9 | | 1 | Og. Citizen of | What Coun | itry? | | |
| | th with | Funeral Director | 1512 LEMONTREE | LANE | | | 2090 | 4 | | 11 | SA | | 1 2 3 3 | | |
| | items 2 | Jer | 11. Meritei Stetus | 12. Wes Deceden | | S. 13. V | Ves Decedent of Yes, specify C | | Origin? (Spec | | 14. Rac | | | | |
| 020 | 를 하를 | þ | 1 Never Merried 2 Merrie 3 Never Merried 2 Merrie | Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes | No | . 1 | Yes, specify C | | | ican, etc.) | - | | | | |
| Ö | 2 ho | Pe | 15. Decedent's (Specify only highest | Education | WILL | 16s Deced | lent's Usuel Oc | cupation | | | 16b. Kind of B | usiness/inc | dustry | | |
| 21215-0020 | within 7 ene. then 'n | Completed | (Specify only highest Elementery/Secondery (0-12) | College (1-4or | 5+) | | kind of work do OO NOT use rei | ne during m ired) | ost of working | 7 | A DMV | | | | |
| | Hygid Hygid | | 17. Father's Neme (First, Middle, L | · | | OFFI | JEK | 18. Mo | fher's Neme | First, Middle, I | | ne) | | | |
| Maryland | d be ental | To Be | JOHN WILLIAM B | RADI.EY | | | | ELLA JOSEPHINE CUFF | | | | | | | |
| 37 | should nd Men marks ametic | - | 19e. Informent's Neme/Reletionshi | | | 19b. Meilin | a Address (Str | | | | | State Zin | Code) | | |
| | nd2 offh a 27 is r frei | | KAREN LEE BROWN | | |) | | | | | | | | | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: if flem 27 is marked other than "natural", any Injury or other traumatic event, tra Medical Execute. | | 20e. Method of Disposition 1 Buriei 2 Cremetion | | Ce | eca of Dispo emetery, cren | sition (Neme of netory or other | olece) | | | | | | | |
| 音 | rtant njury | | 4 □ Donetion 5 □ Other (Spe | 4 | ARI | | NATIO | | | | | | | | |
| Ba | permit. Departr Importu any inji | 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility JOSEPH GAWLER'S SONS, INC 5130 WISON.W., WASHINGTON, D.C. 20016 | | | | | | | | | | | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): | | | | | | | | | est, | 1 | Interval Between | | | |
| - | D # | line. | Pancreatic Carcinoma | | | | | | | | | | | | |
| | and Ftran | Examiner | Sequentially list conditions, | U. | Due to (or | es e conseq | uence of): | | | | | | | | |
| 60, | cian cian buria | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | | ! | | | |
| 68760, | rtificate be executed ng physician and ses the burlat-transit | Medical | resulting in deeth) Lest | | | | | | | | | | | | |
| Box | death cert e attendin od for use | Physiclan/N | | d | | | | | | | | i | | | |
| | 0 0 0 | sic | Part II. Other significant condition | s contributing to death I | but not resul | lting in the un | nderlying cause | given in Pa | rt I. | 23b. Did to | bacco usa co | ntribute to | the cause of death' | | |
| s, P.O | requires that the death een signed by the atte hould be detached for | by Phy | | | | | | | | 10 Y | 88 2⊠ No | 3 Prot | ably 4 Unknow | | |
| Records, | aw requir is been s 2 should | Completed I | | | | | | | | | | ava | nilable prior to repletion of cause | | |
| | E 28 8 | Som | | | | | | | | 1 🗆 Ye | s 25 No | 10 |]Yes 2□No | | |
| of Vital | ysicien: The | Be (| 25. Wes case referred to medical exeminer? | | | | | 26. Pk | ace of Deeth | Check only on | е) | | | | |
| 1 | 5 m 5 | To | 1 ☐ Yes 2 ☑ No | Hospitel: 1 ☐ Inpati | ient 2 E | ER/Outpatien | 3 DOA | Other: 4 | Nursing Hom | e 5X Reside | ence 8 Oth | er (Specify | 0 | | |
| 0 0 | ter th | | 27. Menner of Death 1 ☑ Neturel 5 ☐ Pending | 28a. Dete of Inju | ury av Year) | 28b. Time of Injury | 28c. lr | jury et Vork? | 28 | d. Describe ho | w injury occur | red | | | |
| 000 | Attending in death. | atic | 2 Accident investiga | tion | , | ,, | | ☐Yes 2 | □No | | | | | | |
| Division | al or Atte s after de il Directe d in by t | Certification: | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | ed 28e. Piece of in | ijury - At hor tc. <i>(Specify)</i> | me, ferm, stre | eef, fectory, office | 08 | 28 | f. Location (St City or Town | reet end Numb n, State) | per or Rure | Route Number, | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | edical (| 29e. Certifier (Check only one) 1 Certifying 2 Medicat Ex | Physician: To the best caminer: On the basis of end menner si | of examinetic | rledge, deeth on and/or inv | occurred et the estigetion, in m | time, dete y opinion, d | and piece, an | d due to the call at the time, d | ause(s) and ma ete end piece, | anner as st and due to | eted. the cause(s) | | |
| | To the within 2 To the comple | Me | 29b. Signature and title of ceptiller | 1 1 | | | 29c. Lice | ense numbe | or . | 2 | 9d. Dete signe | d (Month, I | Day, Year) | | |
| | - > F 0 | | DA XII | -1) our | | | 110 | 88 - 1 | C. | | 1/20 | lar | | | |
| | | | 30. Neme and address of person w | no completed cause of | death (Item | 23a) (Tuno 1 | 11. | 00 .1 | | | 4 70 | 176 | | | |
| | | | Roy K. H. Wong, | | | | AVE. N. | W. | JASHTNO | GTON, D | .C. 20 | 0307 | | | |
| | Sta | te | 31. Dete filed (Month, Day, Year) | 32. Regist | rer's Signetu | ure 🙇 | 1/ | | | , | | | | | |

JAN 31 1996



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burial-transit

completely filled in by the tuneral director, page 5 should be detached for use as the rial, cremation, or removal

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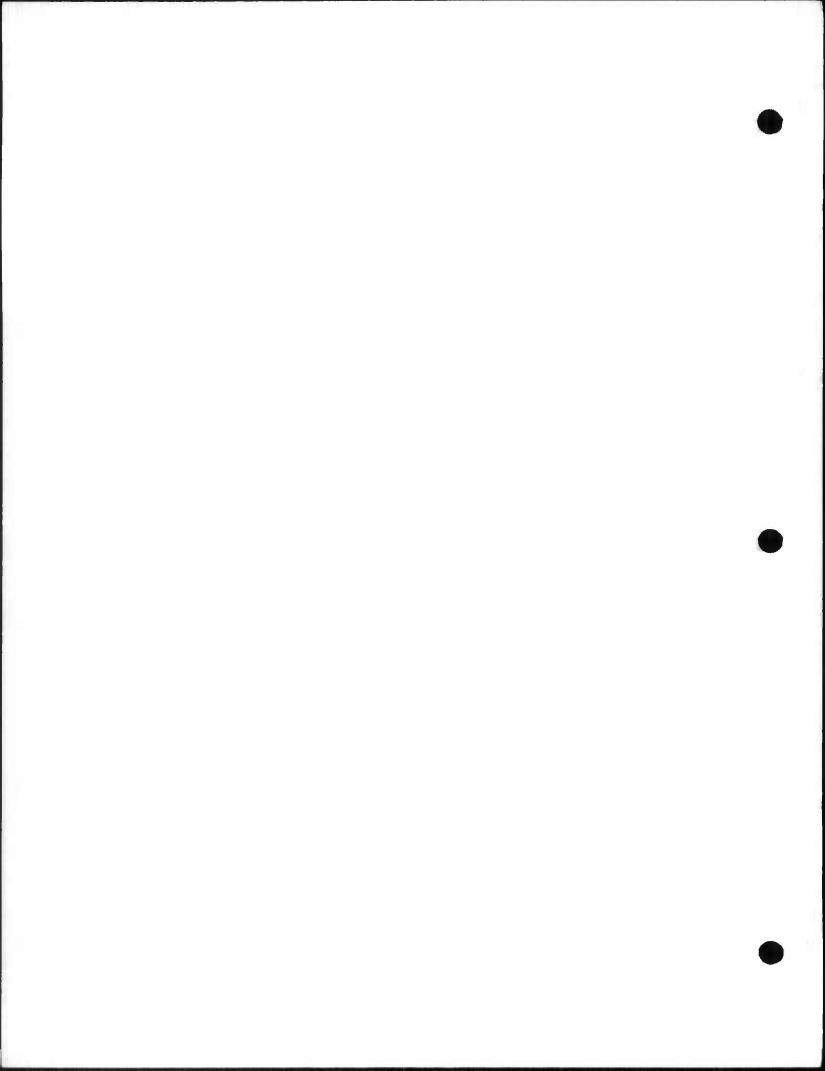
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| F VITAL RECORDS, P.O. BOX 68760 | te be executed within 24 hor |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR Sandra Α. Becker January 23,1996 3:30 P.M. 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Ybar, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS DAYS 1 M 2-F YRS. 70 213-38-1932 August 8,1925 Washington, DC 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital 01nev Montgomery 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery 01ney 1 YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 19212 Willow Grove Road 20832 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE --- American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 X Married B 1 TES 2 NO Specify: Specify: 3 Widowed 4 Divorced White ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET Food/Entertainment Elementary/Secondary (0-12) College (1-4 or 5 +) 0 Waitress Restaurant once 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) notified at Joseph Roccella BE Jennie Pilla 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 5 Vincent Victor Becker 19212 Willow Grove Road, Olney, MD 20832 9 20s. METHOD OF DISPOSITION
1 TO Burlel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE High Gate of Heaven Cemetery 1-26-96 Silver Spring, MD medical examiner 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home 21. SIGNATURE OF FUNERAL SERVICE CICENSES 11800 New Hampshire Ave., Silver Spring, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ DUE TO OR AS A CONSEQUENCE event, resulting in death) second Advianced
DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING THE TO (OR AS A CONSEQUENCE OF): other t CAUSE (Disease or Injury that initiated events resulting in death) LAST rombody 0 PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS 23 shows any AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 THO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 740 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? marked, Natural 28d. OESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 YES 2 NO BY Accident 28s, PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 69 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 28 29a, CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. = 2 MEDICAL EXAMINER: Onli TO THE HOSPITA
TO THE FUNERA
De filed within 7. n and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ami 39190 Junuary 25 1996 2

31. DATE FILED (Month, Day, Year) JAN 29 1996 32. REGISTRAR'S SIGNATURE

Joseph G. Reilly, MD, 3418 Olanwood Court, #111, Olney, Maryland 20832

ADDRESS OF PERSON WHO COMPLETED CAUSE OF COATH (ITEM 27) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

03655 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** BOYD SR. JANUARY 25. 1996 FARI 7:21 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12 SOUTH FREDERICK #208 GAITHERSBURG AVENUE MONTGOMERY If Undar 24 Hrs. Hours Min. 8. Data of Birth Month, Pay, AUG. 19 If Undar 1 Year 9. Birthplaca (Stata or Foreign Country) VIRGINIA 7. Aga (In yrs. last birthday) **Funeral** Months 1 XM 2□ F Days Yrs 70 **Director** 212-20-1412 Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 12 Yas 2 No Director MARYLAND MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" and virtually or other traumatic events. 20877 #208 UNITED STATES 12 S. FREDERICK AVENUE Funerai 12. Was Decedant Evar in U,S. Armed Forcas? 1⊠Yas 2 □ No If Yas, Giva Yaar or Datas: W . W . I I Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. 1 Navar Married 2 Married 1□ Yas 2 No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN 0 ELECTRIC 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be KANSADIE PRESLEY (UNKNOWN) 2 19a. Informant's Name/Raiatlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) DOROTHY M. BOYD WIFE 12 S. FREDERICK AVENUE, GAITHERSBURG, MD. 20877 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burlai 2 □ Cramation 3 □ Ramoval from State MD. VETERANS CEMETERY 1/31/96 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND 21. Signature of Funarel Service/Ligansee 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038 LAYTONSVILLE, MARYLAND 20882 23a. Part / Entar tha disass, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarvai Batween Onset and Death Physician MONTH Immediete Cause (Final disaasa or condition rasulting in daath) /Medical SMALL CELL CANCER Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the bunial-transit Sequantially list conditions, if any, leading to immadiate cause. Enter Undarfying Causa (Disease or Injury thet initiated avants rasuiting in death) Last and Dua to (or as a consequence ot) Box 68760. physician Physician/Medical Dua to (or as a consequence ot) attending e detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 2 Yee 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy Completed peen has this certificate 275 No 1 Yas 2 No 1 Tyes after death.

Director: After this certifications director. Be 25. Was casa rafarrad to medical axaminar? 26. Piaca of Deeth (Check only one) Hospitei: Other: 4 Nursing Homa 2 1 Yas 2 No 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 DOA funerai 28a. Data of Injury (Month, Day Year) Mannar of Death
Natural
Accident Certification: 28b. Tima ot 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding investigation 1 ☐ Yes 2 ☐ No the Could not be 3 Suicida 28t. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, tectory, office building, atc. (Specify) 4 Homicide 24 hours a Certifying Physictan: To the best of my knowledge, daath occurred at the time, dete end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, daath occurred at the time, deta and place, and due to the ceuse(s) and manner stated. 29e. Cartifia: Medical To the Vithin 2 29b. Signatura and title of certifian 29c. Licensa number 29d. Data signed (Month, Day, Year) JANUARY 26, 1996 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)
DR. CAROLYN A. HAMMETT, 6111 EXECUTIVE BOULEVARD, ROCKVILLE, MARYLAND Apgistrar's Signaturo 31. Data filed (Month, Dey, Year) JAN 291996State

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

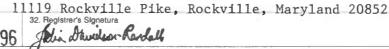
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|------------|---|--|--|---------------------|--------------------------|---------------------|--------------------|--|----------------|--------------------|--------------------|--|---|---|--|--|--|
| | Physic | ian | Decedent's Neme (First, Midd | | | | | | | | | 2. Dete of Deeth 3. Time of Death Month Dey Year | | | | | |
| | /Medi | | DAVI | | BRUC | E | В | ECKER | | | | JANUA | | | 1:36 P.M | | |
| | Exami | ner | 4e. Facility Neme (If not Institution | | iumber) | | | | | | | ocation of Deat | | y of Deeth | | | |
| - | | | 20052 LAKE PAR 5. Social Security Number | 6. Sex | 7 400 | (In yrs. last birth | ludou | If Under 1 Yea | | ERMAI f Under 2 | | | | TGOME | | | |
| | Funeral Director | | 020-36-3987 Usual Residence of Decedent | 1 ∑ M 2□ F | | | rs. | Months Dey | | Hours | Min, | 8. Dete of Bi (Month, Do JAN 9, | 1947 | CA | place (Stete or Foreign NADA | | |
| | land | | 10a. Stete 10b. County 10c. City, Town or Location | | | | | | | | | | | 1 | Od. Inside City Limits | | |
| | e Mary | Director | MD MONTG | OMERY | | GERMA | NTO | WN | | | | | | | 1 ☐ Yes 2 ☐ No | | |
| | 4 2 2 Z | Dire | 10e. Street and Number | | | | | 10f. Zip Code | | | | | 10g. Citizen of | Whet Cou | ntry? | | |
| | 23a | | 20052 LAKE PAR | K DRIVE | | | | 2087 | | | | | UNITE | D STA | TES | | |
| | filed within 72 hours efter death with the Maryland Hygiena. Idher than "naturel", or Neme 23a or 28e-f ehow ent, the Medical Examinel must be notilled at | by Funeral | 11. Meritel Stetus 1 □ Never Merried 2 □ Me 3 □ Widowed 4 ▼Divorce | If Yes C | Forces? 2 🔯 N Sive | | | /es Decedent of Yes, specify Cu ☐ Yes 2 🕅 No | | | in? (Spi Puerto | ecify Yes or No Rican, etc.) | Speci | ice - Americ eck, White, | | | |
| | 2 hou | P | 15. Decede | nt's Education | | 16a. I | Decede | ent's Usuel Occ | upatio | n | | | 16b. Kind of (| | | | |
| | within 72 ana. than *na | Completed | (Specify only higher Elementery/Secondery (0-12) | est grade completed | d) (1-4or 5- | | (Give k life. D | ind of work don O NOT use retii | e durir | ing most | of work | ing | | | , | | |
| | if Hygiena. other than | | 17. Fether's Neme (First, Middle | | | | | EACHER | T 18 | 3. Mother | 's Name | e (First, Middle | | | | | |
| | o da da y | To Be | NATHAN BECKER | | | | | | | SHII | | | | | | | |
| | of Heelth end of Heelth end I item 27 is m if other treum | | 19e. Informent's Neme/Reletion NATHAN BECKER, | | | | | | | | | | GERMANTOWN, MD 20874 Dete 20c. Location - City or Town, Stete | | | | |
| | | | | FAIRER | | 20b. Plece of | Dispos | ition (Name of | | V DK. | LVL, | Dete | | | | | |
| pallimore, | | | 20e. Method of Disposition 1 🖾 Buriel 2 Cremunon 3 Removel from State 4 Donetion 5 Ørper (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) JUDEAN MEMORIAL GARDENS | | | | | | | | | | OLNEY, MARYLAND | | | | |
| | permit. Peg Department Important: It any injury o | | 4 Donetion 5 Other (Specify) JUDEAN MEMORIAL GARDENS 1/28/96 OLNEY, MARYLAND 21. Signeture of Fundal Bervice-Licensee 22. Name end Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. | | | | | | | | | | | | | | |
| | | 23a. Pert1. Enject the disease of domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart feiture. List gnly one cause on each line. | | | | | | | | | | | | | | | |
| | Physician | | | | | | | | | | | | | | | | |
| | /Medical | | Immediate Cause (Final disease or condition resulting in death) e. ARTERIOSCLEROTIC (MRDIOVASCULAR DISEASE) | | | | | | | | | | | | INDEF | | |
| | Examiner | | resulting in deeth) | e./TR/E | | Due to (or es e co | | | VA | 47 C C | LA | | TACKE | 60 | 110001 | | |
| | D 45 | ine | | | | | | | | | | | | | | | |
| | wacute end al-trans | хаш | Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): | | | | | | | | | | | | | | |
| | e be e sician e buri | | | | | | | | | | | | | | | | |
| | certificate be executed iding physician end ise as the burial-transit | Medi | | | | | | | | | | | | | | | |
| | | clan | | 4. | | | | | | | | | | | | | |
| | that the death hed by the attar deteched for ta | Physician | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | | | | | | bacco use contribute to the cause of death? | | | |
| | s that ined by | by Pt | | | | | | | | | | 1 | Yes 2∐ No | City or Town, Stete, Zip Code) COWN, MD 20874 Oc. Location - City or Town, Stete OLNEY, MARYLAND CHAPELS, INC. LLE, MD 20852 st, Approximate Interval Between Conset and Death Occupy Individual Conset and Death Occupy Individual Completion of cause of death? autopsy ed? 24b. Were autopsy findings availeble prior to completion of cause of death? 1 Yes 2 No | | | |
| | w requiras that been signed b should be dete | Completed b | | _ | | | | | | | | | an autopsy ormed? | av | eileble prior to impletion of cause | | |
| | The law ate has b page 2 s | шс | | | | | | | | | | 10 | Yes 25% No | | | | |
| | ician: Th certificate rector, pay | 0 | 25. Wes case referred to medica | nI - | - | | | | 26 | 6 Plane | of Doot | h (Check only | | | 163 20140 | | |
| | | 0 0 | exeminer? 1 X Yes 2 □ No | Hospital: |] Inpatien | t 2 ER/Out | netient | 3□ DOA C | whor. | | | | | her (Specia | 5/I | | |
| | | | 27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pendi | 28e. Dete (Mo | | / 28b. Ti | | 28c. Inj | ury et ork? | | | | | | <i>y</i> 7 | | |
| | the the | ertification: | 2 Accident Invest 3 Suicide 6 Could 4 Homicide determ | nined 288. Pled | | ry - At home, feri | m, stre | | | 8 2 1 | | | | ber or Rur | al Route Number, | | |
| | pital or At ours efter d eral Direct filled in by | 0 | | | | | | | | | | | | | | | |
| | Fun 4 h | edical | | Examiner: On the | | examinetion end | | | | | | | | | | | |
| | within 2 To the comple | 2 | | | | | | | | | | | 29d. Date sign | ed (Month, | Dey, Year) | | |
| | | JANUARY DOTOGG JANUARY | | | | | | | | | Y 27, | 1996 | | | | | |
| | | | 30. Neme end eddress of person | | | | | rint) | | | | DOS. | m 000 | 1.7 | | | |
| | | | FRANCIS C. MAY 31. Dete filed (Month, Dey, Year | LE, M.D., | 102 | 15 FERN | WOO: | D ROAD, | #3 | SOT E | BETH | ESDA, 1 | MD 208 | 17 | | | |
| | Sta Registr | _ | IAN 9 | 2 9 1996 | Valia | Amalian . | Rand | lall | | | | | | | | | |
| | 3 | | JAN | JULU G | June | | _ | | | | | | | | | | |

| | Amende | ed | #4a, 10e, MRT, 2/1, | | aryland g. Cty | Y · Cer | tificate | e of | lealth and Death | | Reg. No. | 96 | 03657 | | |
|---------------------|--|--|--|---|--------------------------|---|--------------------|--------------------|-----------------------------|---------------------------------|--------------------|------------|---|--|--|
| - 11 | Physic | ian | Decedent's Neme (First, Middle, Last |) | | | | | | 2. Dete of D Month | eath Day | Yeer | 3. Time of Death | | |
| | /Medi | | Claudia Thomas Bu | | | | | | | Januar | cy 27, 1 | 996 | 11:30am | | |
| | Exami | ner | 4e. Fscility Neme (If not institution, give | 1 | | | | 4 | lb. City, Town, o | r Location of Dee | th 4c. Count | y of Deeth | | | |
| | | | 2020 Baltimore Ro | | | | M I Indon | | Rockvill | | Mon | tgome | | | |
| 1 | Funeral | | 5. Sociel Security Number 6. Se | x 7.Aq]M 2 ² —— 7.Aq | | ist birthdey) Yrs. | If Under Months | Deys | If Under 24 H | n. (Month, E | irth Dey, Year) | | place (State or Foreign intry) | | |
| | Director | | Usuei Residence of Decadant | | 77 | 114. | | | | April | 8, 1918 | Noi | rth Carolina | | |
| | /land | | 10a. Stete 10b. County | | 10c. City, | Town or Loc | cation | | | | | | 10d. Inside City Limits | | |
| | the Maryland r 28a-f ahow | tor | Maryland Montgome | rv | Rock | ville | | | | | | | 1 ☐ Yes 2 🖾 No | | |
| | or 28s | Director | 10e. Street end Number | Ly | MOCK | ATTTE | 10f. Zip | Code | | | 10g. Citizen of | Whet Cou | intry? | | |
| | deeth with the Maryland rms 23a or 28a-f ahow rms the notified at | aπ | 2020 Baltimore Ro | ad #K-2 | 22 | | 21 | 0853 | | | United | Stat | . 60 | | |
| | items ? | Funeral | 11. Meritei Stetus | 12. Wes Decedent Armed Forces? | Ever in U,S | | Ves Deced | ent of H | Ispanic Origin? | Specify Yes or N | lo- 14. Re | ce - Ameri | ican Indien, | | |
| 0 | or he | 3 | 1 Never Merried 2 Merried | 1. XYes 2 ☐ | | | Yes, spec | Ť | n, Mexican, Pue Specify: | eno Hican, etc.) | | ck, White | , etc. | | |
| 00 | | 1 by | 3 ☐ Widowed 4 ☒ Divorced | Yeer or Detes: | WWII | | LI 165 2 | EN IND | <i>Зреспу:</i> | | Specify: White | | | | |
| 5 | n 72 hours | Be Completed | 15. Decedent's Edu (Specify only highest grad | cation e com <i>pleted)</i> | | 16e. Deced | ent's Usue | Occupa | ation during most of w | rorkina | 16b. Kind of B | usinass/Ir | ndustry | | |
| 121 | d within plene. r then | du | Elementery/Secondery (0-12) | College (1-4or | 5+) | lifa. D | OO NOT us | e ratired |) | | | | | | |
| 7 | 77 m h 100 | S | 12 | | | Secre | etary | | | | Federal Government | | | | |
| and | 12 should be filed within h end Mental Hyglene. 7 is marked other than 'traumatic event, I'm Mental than the contraction of the Mental than the contraction of the Mental than the Mental than the Mental than the Mental th | | 17. Fether's Neme (First, Middla, Last) | | | | | ĺ | 18. Mother's N | eme (<i>i-irst, Middi</i> | e, Melden Sumei | ne) | | | |
| Ž | d Me | 10 | Thomas C. Burgess | | | V-1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 | 2011 | 100 | | e A. Car | | ~ | Total Control | | |
| Maryland 21215-0020 | d2 si th em 7 is n | | 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, St. 100. Linter Street Coath organizations ADD 208 | | | | | | | | | | p Code) | | |
| o, | Heall Heall ther | Dominic Burgess (Son) 100 Water Street, Gaithersburg, MD 2087 | | | | | | | | | | | our State | | |
| Baltimore, | M H H | | 20e. Method of Disposition 1 🗆 Buriel 2 🕮 Cremetion 3 🗆 Removel from Stete 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State | | | | | | | | | | | | |
| ij | it. Parturant | | | | Met | | | | | | | | , Virginia | | |
| Ba | permit. Pages 1 and 2 should be filed Department of Health end Mental Hyg Important: If Item 27 Is marked other any follury or other traumatic event, ORGE. | 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Pert Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. | | | | | | | | | | | | | |
| | | | 23a. Perta. Enter the diseese, or compi shock, or heart failure. List only or | icetions that caused na cause on eech II | the deeth. | Do not ente | er the mode | of dyln | g, such es cardi | ac or respiretory | arrest, | 1 | Approximete Interval Between | | |
| | Physician /Medical | ш | Immediate Cause /Finei | | | | | | | | | 1 | Onset and Death | | |
| | Examiner | | Immediate Cause (Final disease or condition rasulting In deeth) | Cardiop | ulmon | ary Ar | rest | | | | | 1 | Minutes | | |
| | | 20 | | | Due to (or | as e consequ | uence of): | | | | | | | | |
| | nsit | 듣 | | Cardiac | | | | | | | | - | 1 Month | | |
| _6. | and and el-tra | Examiner | Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury | | Due to (or e | es e consequ | uence of): | | | | | 1 | | | |
| 68760, | icate be executed physician and s the buriel-transit | <u>a</u> | Cause. Enter Underlying Ceuse (Disease or injury thet Initiated events | Coronar | - | | | 3 | | | | 1 | 10 Years | | |
| 687 | ficate phy: | edical | resulting In deeth) Lest | | Due to (or e | es e consequ | ience of): | | | | | 1 | | | |
| Box | certif ding use a | 3 | | l | | | | | | | | | | | |
| B | death certifica e attending ph od for use as t | Physician/M | 0 1 0 1 1 1 | 14-2 | | | | - 3115 | | 4 | | 1 | | | |
| 0 | that the de ed by the detached | ysl | Pert il. Other significent conditions con | itributing to death b | ut not result | ting in the un | darlying ca | luse givi | en In Pert i. | | | | to the cause of death? | | |
| О. | | by PI | Recent History of | Gastroin | testi | nal Bl | eedir | ng | | . 1L | Yes 2 No | 3 L Pro | bebly 4 Unknown | | |
| ecords, | een signe | | | | | | | | | 24a. Wa | s en autopsy | | Vera eutopsy findings | | |
| 8 | S O | lete | | | | | | | | per | iormed? | CI | veileble prior to empletion of cause f death? | | |
| Re | The law ate hes page 2 | Completed | | | | | | | | | lv. ofth. | | | | |
| Vital | | | 25. Wes casa referred to madical | | | - | | | 00 01 | | Yes 201No | | ☐ Yes 2☐ No | | |
| > | | o Be | exeminer? | lospital: 1 ☐ Inpatie | not 2 🗆 E | R/Outpetiant | 3□ DO | Oth | DP1 | eath (Check only Home 5⊠ Res | | ne /Cnaci | 16.1 | | |
| of | F the | | 27. Manner of Death | 28a. Date of Inju | ry 2 | 28b. Tima of | | Bc. Injury Work | | 1 | how injury occur | | 197) | | |
| Division | # - 문화 | tion | 1 ☑ Naturei 5 ☐ Panding 2 ☐ Accident investigation | (Month, De | y Year) | Injury | М | | <7 Yes 2 □ No | | | | | | |
| 7.5 | or Attendir after death. Director: Af | Iffice | 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of Inj | ury - At hom | ne, ferm, stre | at, factory, | office | | | | ber or Rur | ral Route Number, | | |
| Ö | 10年 10日 | Certification: | 4 Homicide | building, et | c. (Specify) | | | | | City or To | own, Stete) | | | | |
| | To the Hospital of within 24 hours a To the Funeral Completely filled | | 29e. Certifier 1∑ Certifying Phys | | | | | | | | | | | | |
| | n 24 n 24 ne Fu | edical | (Check only 2 Medical Examinate) | ner: On the basis of | | on end/or invi | astigetion, | In my of | oinion, daeth oc | curred et tha tima | , data end piece, | end due t | o the cause(s) | | |
| | To the To the Comple | Σ | 29b. Signature and tale of certifier | 1/1 | | | 29c. | License | number | | 29d. Date signe | d (Month, | Dey, Year) | | |

State Registrar

Takao L. Sato, MD 31. Dete filed (Month, Day, Year)

30. Nama and addrass of person who complated cause of daeth (Item 23a) (Type, Print)



D 44120

January 27, 1996

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03658

| | | | | Certificate of Death | Reg. No. | | | | | | |
|----------------------------|--|----------------|--|--|---|--|--|--|--|--|--|
| | Physici | an | 1. Decedent's Nema (First, Middle, Last) | 1.10 | 2. Data of Death Month Day | 3. Time of Deeth | | | | | |
| | /Medic | | SARAH L. COLL | INS | JANUARY 21/1 | 996 11.15 Pm | | | | | |
| 7 | Examir | ner | 4a. Facility Neme (If not institution, give street and number) | 4b. City, Town, or I | ocation of Death 4c. County | of Death | | | | | |
| Н | Francis | | 5 Social Security Number 6. Sex 7. Aga (In yrs. las | DIA BAI | 8. Data of Birth | 9 Birtholace (State or Foreign | | | | | |
| a. | Funeral Director | | 214-126-416 1 M 2 X F 87 Usual Rasidance of Dacedant | Yrs. Months Days Hours Min. | 8. Data of Birth (Month, Day, Year) 9-7-1908 | 9. Birthplace (Stata or Foraign Country) | | | | | |
| | nyland | | | own or Location | | 10d. Inside City Limits | | | | | |
| | Se-f | Director | Ma Somerset M | ATION | | 1 □ Yes 2 No | | | | | |
| | with th | Dire | 10e. Street and Number | 10f. Zlp Coda 21838 | 10g. Citizen of V | Vhat Country? | | | | | |
| | eath ' | Funeral | 11. Marital Status 12. Was Decedant Evar in U.S. | | pacify Vas or No. 14 Bace | e - Amarican Indian, | | | | | |
| 21215-0020 | ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avent, the Modical Exercities must be inclined at | þ | Armed Forcas? 1 Navar Married 2 Married 1 Yes 2 No II Yas, Giva Year or Datas: | 13. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Mexican, Puert 1 ☐ Yas 2 MNo Specify: | o Rican, etc.) Blec Specify | k, White, etc. | | | | | |
| 5-0 | 72 hours "natural", | Completed | 15. Decedant's Education 10 (Specify only highast grade completed) | 6a. Decedant's Usual Occupation (Giva kind of work done during most of wor | kina 16b. Kind of Bu | sinass/Industry | | | | | |
| 121 | within lene. than " | mp | Elementary/Secondary (0-12) Collega (1-4or 5+) | (Giva kind of work done during most of worlifa. DO NOT use retired) | Dom | estic | | | | | |
| | Hygie ther mrt, II | Co | 17. Fathar's blama (First, Middla, Last) | LABOREY 18. Mothar's Nar | na (First, Middle, Maiden Sumam | | | | | | |
| lan | should be nd Mental marked or | To Be | Burtram Holden | JENC | . 11 // | , | | | | | |
| Maryland | 2 shou and N is mar | _ | | 9b. Melling Addrass (Street and Number or Ru | * | State, Zip Code) | | | | | |
|), R | Health Health em 27 i | | LUELLA C. ford | 6713 Chisholm L | r. BALT. Md | , 21207 | | | | | |
| Ore | Peges 1 nent of H int: If iter iry or oth | | 20a. Method of Disposition 1 Burial 2 Crametion 3 Ramovel from Steta | of Disposition (Nama of atary, cramatory or other place) | 227 111 | City or Town, Stata | | | | | |
| Baltimore, | Pe Int | | | NKIRV CEMELRY | -1-96 MAY | imsco Widi | | | | | |
| Ba | permit. Departr importu any inju | | 21. Signeture of Ameral Consult Learning | 22. Nama end Addrass of Facility | - 11 V | 71853 | | | | | |
| | | | 23a. Part1. Enter the deepart of complications that caused the deeth. I | 30639 IAM pde | or raspiratory arrest. | Approximete | | | | | |
| И | Physician | | 23a. Part1. Entar tha disease or complications that caused the daeth. Dishock, or haert failed it ist only one cause on each line. | and the model of office of the second | or raspiratory arross, | Intarval Between Onsat and Death | | | | | |
| | /Medical | | Immediata Causa (Final disease or condition Gangren | ous Bowels | | 16 hours | | | | | |
| п | Examiner | | Due to (or as | a consequence of): | | 0 000 | | | | | |
| _ | led lesit | nine | mesente | ric infarction | | Laugs | | | | | |
| · · | rtificate be executed ng physician end ses the burial-transit | Examine | if any leading to Immediate | a consaquance of): | | | | | | | |
| 68760, | ysicia ysicia | | cause. Enter Underlying Cause (Disassa or injury that initiated avants Dua to (or as | e consaquence of): | | | | | | | |
| 89 | ntifica ng ph | Medical | rasulting in datur) cast | | | | | | | | |
| Box | death certificate be executed attending physician end for use es the burial-transit | lan/ | d | | | | | | | | |
| P. 0. | 0 0 | Physician/ | Part II. Other significant conditions contributing to death but not rasulting | g In tha underlying causa given in Pert I. | 23b. Did tobacco usa con | ntributs to the cause of death? | | | | | |
| ۵. | The law requires that the death co ate has been signed by the attend page 2 should be deteched for us | | | | 1 ☐ Yes 2 ☐ No | 3 Probably 4 Unknown | | | | | |
| rds | v requires been sign should be | ed by | | | 24a. Was an eutopsy | 24b. Wara autopsy findings evailebla prior to | | | | | |
| 000 | aw requisite by the second sec | plet | | | performed? | completion of causa of death? | | | | | |
| œ | The lay ate has page 2 | Completed | | | 1□ Yas 2 No | 1 Yas 2 No | | | | | |
| Vita | ician: The certificate rector, pag | Be | 25. Was casa refarred to medical axaminar? | | ath (Check only ona) | | | | | | |
| o | Physic this o | . To | | The state of the s | oma 5 ☐ Rasidence 6 ☐ Othe 28d. Dascribe how injury occurr | | | | | | |
| Division of Vital Records, | or Attending Physician: efter death. Director: After this certific i in by the funeral director, | Certification: | 1 Netural 5 Panding (Month, Day Year) 2 Accident invastigation | o. Tima of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | 25d. Dasonos now injury count | | | | | | |
| N N | er death. ector: A by the fu | tifica | 3 Suicida 6 Could not be detarmined 28e. Piece of Injury - At homa building, atc. (Specify) | ferm, street, fectory, office | 28f. Location (Street and Number City or Town, Stata) | er or Rural Route Number, | | | | | |
| ō | ital or A irs efter ral Directled in by | | | | | | | | | | |
| | To the Hospital or Attending Physician: The I within 24 hours effect death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | edical | 29a. Certifiar (Check only only) 2 Madical Examinar: On the basis of examination and manner stated | lga, daath occurred at tha time, dete end plece and/or Invastigation, In my opinion, daath occu | , and due to tha cause(s) end me rred at tha tima, data and place, a | nner as stated. and dua to tha causa(s) | | | | | |
| | To the within 2 To the comple | Mec | and mornar stated. | 29c. License number | 29d. Data signed | d (Month, Dey, Year) | | | | | |
| | - s - ō | | James Loter un | D2554 | 2 Janua | 1ry 21, 1996 | | | | | |
| | | | 30. Nama and address of person who completed cause of deeth (Itam 23) | a) (Type, Print) | ^ . | 1000 | | | | | |
| | | | 29b. Signetura and titla of certifier Sypus Solution | Samar, tan Itospi | tal, Balto. N | 10.21239 | | | | | |
| | | | A CONTRACTOR OF THE CONTRACTOR | | | | | | | | |

Registrar

JAN2 9 1998 Julia Standard Randall

A STANDARD DES

mary manage with the district

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit | | |
|---|--|--|--|
| attending | ise as the | | |
| ospital or | thed for u | | eń. |
| by the h | be detai | | at one |
| retained | 5 should | | otified |
| тау ре | oc page | | ist be r |
| Page 6 | al direct | | iner mi |
| er death. | the funer | val. | ехаш |
| hours aft | ed in by | or remo | medica |
| rithin 24 | eletely fill | remation | ent, the |
| ecuted w | nd comp | burial, c | atic eve |
| ate be ex | ysician a | prior to | r traum |
| h certifica | nding ph | Hygiene | or other |
| the deat | the atte | d Mental | injury, |
| ires that | signed by | fealth an | ws any |
| law requ | as been | Jept. of h | 23 sho |
| IAN: The | tificate h | e State [| or item |
| PHYSIC | r this cer | th with th | arked, |
| TENDING | TOR: Afte | after deal | 28 is m |
| IL OR AT | L DIRECT | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| HOSPITA | FUNERA | within 7. | TANTE |
| TO THE | TO THE | be filed | IMPOR |

permit. Pages 1, 2, 3 should

| | | | | | | | | | | | | 96 | 03659 | |
|--|--|-------------------------------|--|------------------|-------------|-------------|---------------|------------|----------------------------------|--------------------------------------|---------------------|-----------------------------------|---|--|
| | 1 - FOR STATE REGISTRAR | STATE OF M | IARYLAND / | DEPAR ERTIF | TMENT | OF H | EALTH DEAT | AND I | | HYGIENI REG. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF MONTH | | ν | YEAR | 3. TIME OF DEATH | |
| | Mabel | LOUISE | 2 | Cr | onir | 1 | | | Janua | ry 25 | , 19 | 196 | 1132 A M | |
| | 4. SOCIAL SECURITY NUMBER 508-24-3891 | 5. SEX 1 | 6. AGE (In yrs. less | t birthday) YRS. | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF (Month, D 9 - 2 | 0-19 | 14 | a. BIRTHI | PLACE (State or Foreign BRASKA | |
| | 9a. FACILITY NAME (if not institution, give str | eet and number) | | | 9b. CITY | , TOWN O | R LOCATIO | N OF DE | ATH | | 9c. COUNTY OF DEATH | | | |
| DIRECTOR | CALVERT MEMORI | AL HOSE | PITAL | | PF | RINC | E FF | REDE | ERICK | CZ | CALVERT | | | |
| EG | RESIDENCE OF DECEDENT toa. STATE tob. COUNTY | | | t0c, CIT | Y. TOWN (| OR LOCAT | ION | | | | | tod, INSIDE CITY | | |
| E | MARYLAND C | ALVERT | VERT OWINGS | | | | | | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | | | | | | ZIP CODE | | | 1 | t0g. CIT | IZEN OF WHAT COUNTRY? | | |
| FUNERAL | 7140 PERSIMMON | LANE | | 20736 | | | | | | Ţ | J.S. | Α. | | |
| 5 | t1. MARITAL STATUS | t2. WAS DECEDENT FORCES? 1 | NT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN 1 YES 24 NO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | | IC ORIGIN? | Specify Yea | or No- | 14. RACE | - American Indian, White, etc. | | |
| BY F | t Never Married 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE W | | 10 | | t Tyes, spe | 2 XNO | Specify | n, Puerto Hici / | Puerto Rican, etc.) Black Specifi | | | | |
| | | ATION | 140.05 | 0.00.00.00 | | | | | | | | | MHIIE | |
| E.E. | t5. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working life. De NY use natived.) (Bive kind of work done during most of working life. De NY use natived.) | | | | | | | | | INESS/INI | JUSTRY | | | |
| PLE | Elementary/Secondary (0-12) College (1-4 or 5 +) HOMEMAKER OWN HOME | | | | | | | | | | E . | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 11011 | 211111 | CDIC | 18. MOTH | ER'S NA | ME (First, Mide | - | | | | |
| ш | FREDERICK CAR | L FILTE | ER | | | | MA | RTH | IA LO | UISE | BRU | JMMU! | ND | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) JANICE WAUGAMAN (NIECE) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10 | | | | | | | | | | | | | |
| | | `` | | _ | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2A Cremetion 3 Remo | wat from State | 20b. PLACE | | | | | ODS | OATE | | | City or Tox | RIA, VA. | |
| | 4 Donation 5 Other (Specify) | INSEE / | MEIRO | LOL | | | EMA I | | | 190 | ALEZ | CAND. | KIA, VA. | |
| | milal | K | | V | | | | | JERAL | HOM | E | | | |
| | Topienae | 1 | 1000 | 1 | | | | | RYLAN | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart fellure. Liet only one cause on each line. Approximately are all the cardiac or respiratory arrest, enock, or heart fellure. Liet only one cause on each line. | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | | Onset and Death | | |
| | disease or condition resulting in death) a. Congestive heart failure DUE O (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | 10Tyrs. | |
| _ | Atrial Fibrillation Styre | | | | | | | | | | | | | |
| ERTIFICATION | Sequentielly liet conditions, If any, leading to immediate b. / Trial Brillatins OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| S | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury) | | | | | | | | | | | | 10t yrs. | |
| THE | that initiated events | DUE TO | OH AS A CONSEC | DUENCE O | F): | | | | | | | | | |
| ER | resulting in death) CAST | l | | | | | | | | | | | | |
| C | PART II. Other significant conditions | contributing to | deeth but not r | eeulting | in the u | nderiying | g cause g | lven In | Pert I. 2 | Io. WAS AN | | 24b. | WERE AUTOPSY FINDINGS | |
| MEDICA | Dementin | | | | | | | | , | PERFOR | - | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEC | | et infe | ction | | | | | | | | | | t YES 2 NO | |
| ä | DID TOBACCO USE CONTR | | | TH Y | ES 🗆 | NO [| UNC | ERTAI | N 🗆 | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 28. PLAC | E OF OEA | | - | | | | | | | | |
| YSI | 1 TES 2 NO | 1 Inpetient 2 | ER/Outpetient 3 | □ DOA | 4 Nu | | e 5 🗆 Re | aldenca | 8 🗆 Other (S | Specify) | | | | |
| | 27. MANNER OF DEATH t ☐ Netural 5 ☐ Pending | 28a. DATE OF (Month, D | | 28b. TIN | JURY | | RK? | Tare | 28d. OESCF | HBE HOW II | NJURY OC | CURED | | |
| ВҰ | 2 Accident Investigation | 26a BLACE O | F INJURY — At ho | (| m n | | res 2 | NO | | 011 (01 - 1 | | | loute Number | |
| ED | 3 Suicide 6 Could not be 4 Homicide detarmined | | etc. (Specify) | nine, ierni, | mirewi, tec | tory, orne | | | | Town, State) | ina Numbe | r or nurer n | ioute Number, | |
| | 29a. CERTIFIER . PERTIEVING PHYSIC | NAM. To the heat of | mu kanadada da | ath annual | | | | | | | | 2707 | | |
| COMPLETE | (Check only one) 1 CERTIFYING PHYSIC (Check only one) | | | | | | | | | | | |) and manner as stated. | |
| - 1 | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(a) and manner as attend. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Vear) | | | | | | | | | | | | | |
| H | Muluh. | | | | | | - | | | | ▶ 1 | | 796 | |
| 20 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Non-Print) | | | | | | | | | | | | 1/2/16 | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HEAMOLOUKI 110 HOSPITUL Rd.

31. DATE FILED (Month, Day, Your)

JAN 26 1996 January Randall

1/25/96 Prince Fredrick 20678

• 2 1° 101 | 102 DIVISION OF VITAL RECORDS, P.O. BOX 687604

COMPLETED

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| ÷ | ansit permit. Page | |
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| attending physicia | use as the burial-tr | |
| by the hospital or | d be detached for | d at once. |
| e 6 may be retained | ector, page 5 shou | must be notifie |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | edical examiner |
| ecuted with | nd completely filled burial, cremation, o | atic event, the m |
| ath certificate be ex | ttending physician a | , or other traum |
| requires that the de | en signed by the a | shows any injury |
| HYSICIAN: The law | nis certificate has by with the State Dept. | ted, or Item 23 |
| OR ATTENDING P. | DIRECTOR: After the hours after death w | item 28 is mark |
| TO THE HOSPITAL | TO THE FUNERAL be filed within 72 | IMPORTANT: IL |

96 03660 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTN 3. TIME OF DEATH CROPPER THEODORE JANUARY 22 1996 9:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH
(Month, Day, Year)
(2-02-18 8. BIRTHPLACE (State or Foreign Virginia DAYS HOURS 225-14-3929 1 NM 2 - F YRS 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Berlin Nursing Home Worcester Berlin DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Virginia Accomack Assawomen 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 32082 Wallops Island Rd. 23302 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian Black, White, etc. FORCES? 1 YES 2 NO 1 Never Merried 2 Married If yes, specify Cuben, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: specify: Black ВY 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Truck Driver Produce 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Henry Cropper Mary Harmon notified at BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Aural Aoute Number, City or Town, State, Zip Code) 32082 Wallops Island Rd. 23302 2 Georgia Cropper 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of committee of OATE 4 Donation 5 Other (Specify) 22. NAME AND ACCORESS OF FACILITY
Wharton Funeral 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Home 22171 Wharton RD. Accomac, Va.23301 23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heert felture. Liet only one ceuse on each line Interval Batween IMMEDIATE CAUSE (Finel Onset and Death diseese or condition resulting in death) Conuncin CERTIFICATION Sequentielly list conditions, QUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 X NO ic BY

| DID TOBACCO USE CON | TRIBUTE TO CAUSE OF DEA | 100-10 | IN . | | | | | | | | |
|--|---|--|----------------------------------|--|--|--|--|--|--|--|--|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | HOSPITAL: | 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4\lambda Nursing Home 5 Raeldenca 8 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 XNetural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO | 28d. OEŞCRIBE HOW INJURY OCCURED | | | | | | | | |
| 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY — At he building, stc. (Specify) | 28s. PLACE OF INJURY — At home, ferm, street, factory, office 28s. LOCATION (Street and Number of | | | | | | | | | |

29a. CERTIFIER

(Chack only 1) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner se stated. EDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner as stated.

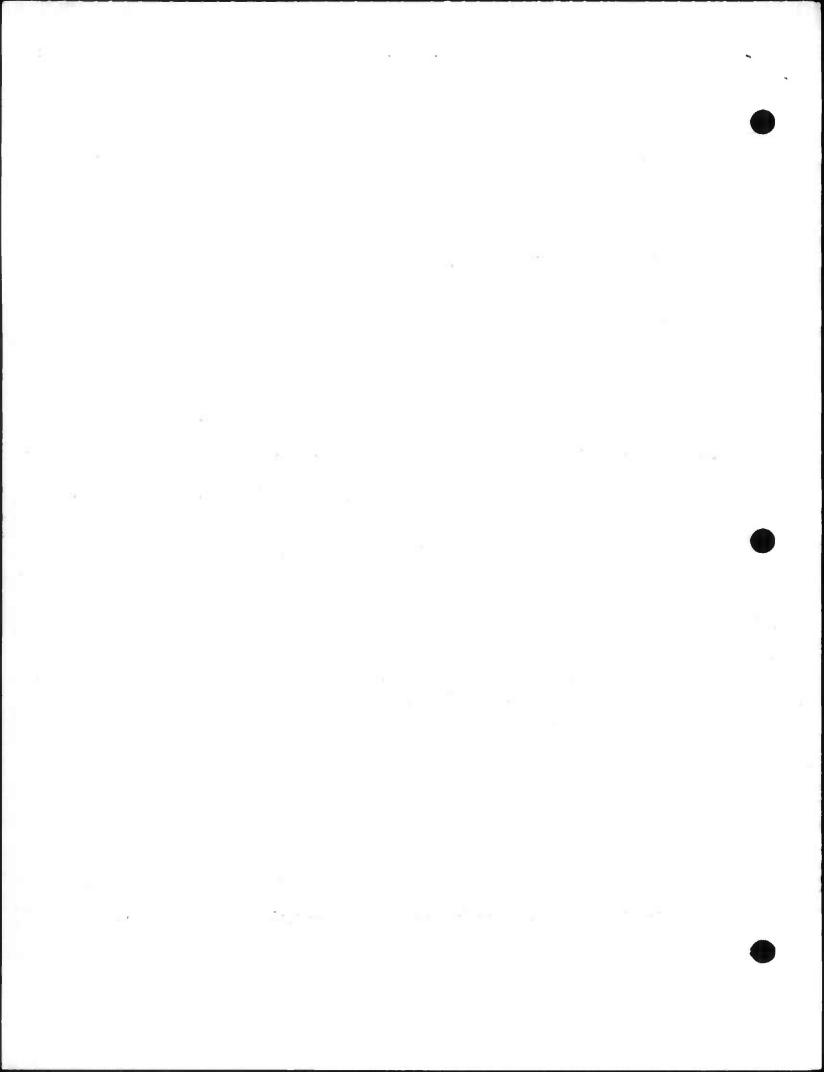
29b. SIGNATURE AND THE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D02026

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

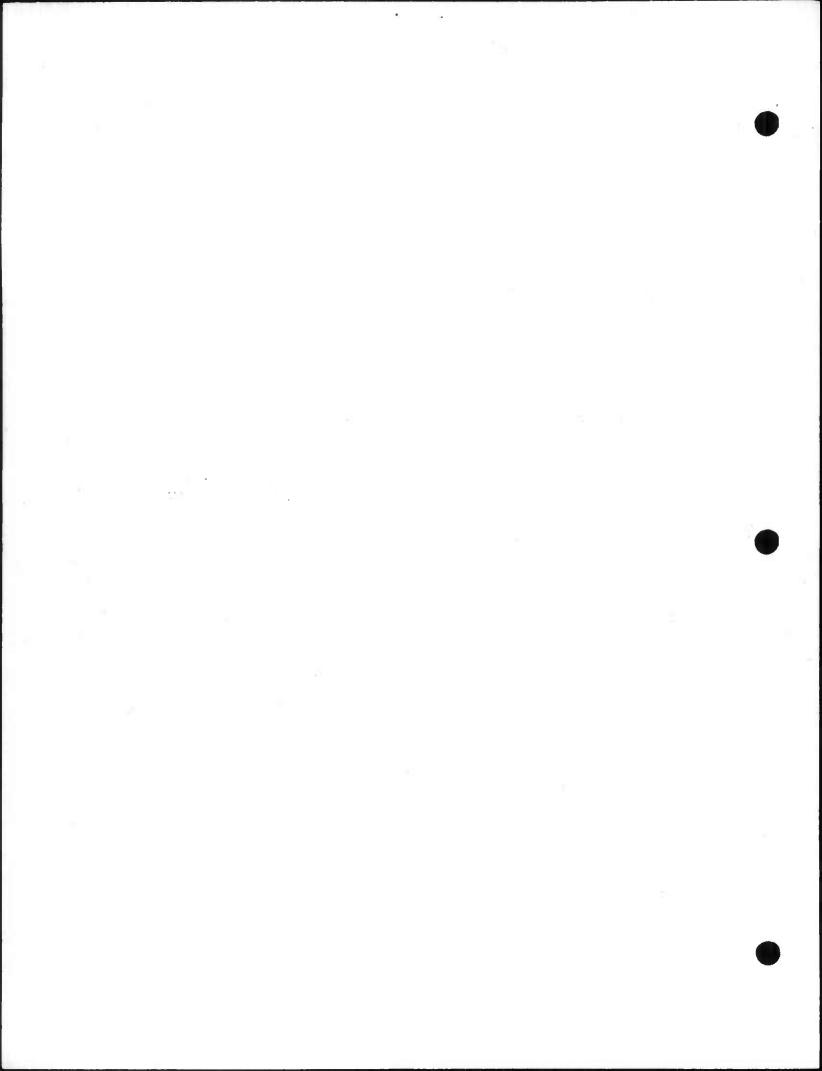
FEDERICO G.ARTHES, MD 1622A OCEAN PINES BERLIN,MD 21811 410-641-4400

32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) in tenden Pardall 1996



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| | | 1 - STATE REGISTRAR | | STATE OF N | MARYLA | ND / DEPAR CERTIF | | | | | MENTA | REG. NO. | | | |
|--|---------------|--|--------------------------|---|-----------------------------|--|--------------------------------------|-------------|---------------|-------------|---------------------|------------------------------------|------------|--------------|--|
| L. | | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | 1 | | - | | OF DEATN | | | 3. TIME OF DEATN |
| | | Evelyn | W. | | | Co | ms | toci | k | | MONT | vary = | | YEAR 196 | 230 Am |
| | | 4. SOCIAL SECURITY NUMBE 175–16–4396 | = 1 | S. SEX | | yrs. last birthday) | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE | OF BIRTH | T | 8. BIRTNPI | LACE (State or Foreign |
| 99 | | 9a. FACILITY NAME (If not ins | | □ M 2 📉 F | 75 | YRS. | | | | | | 29 19 | | | nsylvania |
| 3 sho | œ | Shady Grove | | | pital | ı | | ckvi | R LOCATI | ON OF DE | EATH | | | nty of DEA | **** |
| .2. | 5 | RESIDENCE OF DEC | EDENT | | | | | | | | | | 1.01.030 | | |
| Pages | DIRECTOR | Penn. | Lawren | ce | | | y, town | | | | | | | | ed. INSIDE CITY LIMITS? |
| ET C | | 10e. STREET AND NUMBER | | | | 146 | ew Co | | . ZIP COD | E | | | 40- 007 | 1 YES 2 NO | |
| n. ansit pa | FUNERAL | 226 East Fa: | irmont | Avenue | | | | " | 1610 | | | | | U.S.A. | |
| physician. burlat-transit permit. Pages 1, 2, 3 should | | 11. MARITAL STATUS 1 Never Married 2XXI | Merried | 2. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES | 2 NO | | If yes, spi | ecify Cube | n, Mexica | n, Puerio I | ? (Specify Yea tican, etc.) | or No- | | - American Indian, White, etc. |
| attending se as the | D 8Y | 3 Widowed 4 Divorced | | | | | | | | | | Specify: | white | | |
| _ 3 | E | | DENT'S EDUCAT | mpleted) | | 18a. DECEDENT'S (Give kind of life. Do NOT u | USUAL O work done se retired.) | during mo | St of working | ng | 16b. | KIND OF BUS | SINESS/IND | USTRY | |
| the hospital or detached for once. | COMPLETED | Elementary/Secondary (0- | | years | ') | Bank | | | | | M | ortgag | ge Bai | nking | |
| | OS | 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Surname) | | | | | | | | | | | | | |
| should be strougled at | BE | Clarence M. Wallace Ruth E. Spencer | | | | | | | | | | | | | |
| - w = | 2 | William C. (| | k | | | | | | | | New C | | | . 16105 |
| ter death. Page 6 may be the funeral director, page yval. | | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 4 Donetion 8 Other (| 3 🗌 Remove | i from State | | PLACE AND DATE | | | me of | | Jan | | | City or Town | |
| death, Page funeral dire | | 21. SIGNATURE OF FUNERAL | | SEE | - 110 | CEC CEC | 22. | NAME AN | | | CILITY3, | 96 | | AITTE | , Md. |
| death. Pag tuneral dir d. examiner | | Greger | SKA | / | _ | | | | | | | Home | | Mal | 20707 |
| m > = 0 | | 23. PART I. Enter the dis | eesea, or con | npilcations the | caused | the death. Do | not anter | the mo | de of dyl | ng, auch | h aa card | e Lau | ratory am | eat, | 20707 |
| F = 0 | | iMMEDIATE CAUSE (Fine disease or condition resulting in death) | ni. | meta | | C ACIT | losi | 5-0 | 2+1 | n lo | Qu (1 | nach | (Th | | Interval Between Onset and Death |
| Z 8 - 6 | | | | OUE TO | (OR AS A | CONSEQUENCE O | F): | | | - | 31- | | | | |
| be Sian or 1 | CERTIFICATION | Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN | late | OUE TO | (OR AS A C | CONSEQUENCE O | F): | | | | | | | | |
| the death certificate be of the attending physician of Mental Hygiene prior to injury, or other traum | IFIC | CAUSE (Disease or injury | | DUE TO | OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| tendin al Hygi | ERT | resulting in death) LAST | | | | | | | | | | | | | |
| the deat y the atte of Mental injury, | — и | PART II. Other algnifican | t conditions o | contributing to | death but | t not resulting | In the ur | deriying | cause g | lven in | Pert I. | 24a. WAS AN | | 24b. W | ERE AUTOPSY FINDINGS |
| that by by h an | DICAL | Artorioscl | arotic | Heart I | Isea | sewith | rec | ent | CB | BG | _ | PERFOR | no. | C | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| equire en sig of Hea hows | MED | Rheumati | c Hear | ct Dis | 305c | withs | ecev | 14 (| om | miss | arota | | | | TES 2 NO |
| law ras be Dept. 23 s | AN | DID TOBACCO US 25. WAS CASE REFERRED TO | | BUTE TO CA | | | | 10 N | | ERTAIN | | | | | |
| N: The ficate the State them | SICIAN: | EXAMINER? | H | OSPITAL: | | B. PLACE OF DEA | OTHE | ₹: | -03 | ATAIN THE | | G-NT | | | |
| YSICIA s certii th the rd, or | PHY | 27. MANNER OF DEATN | | 28s. DATE OF | INJURY | 28b. TIM | E OF | 28c. INJU | JRY AT | sidence | 8 Other | (Specify) CRIBE HOW IN | JURY OCC | URED | |
| NG PH her this ath win | ВУ Б | Netural 5 P | ending vestigation | (Month, Di | | | URY M | | ES 2 [| NO | | | | | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires TO THE FUNERAL DIRECTOR: After this certificate has been sign be filed within 72 hours after death with the State Dept. of Healt IMPORTANT: If Item 28 is marked, or Item 23 shows: | G | | ould not be itermined | 28s. PLACE Of building, | F INJURY — atc. (Specify | - At home, farm, : | street, tact | ory, office | | | 28t. LOCA City o | ATION (Street a or Town, Stete) | nd Number | or Rural Rou | te Number, |
| AL DIF | COMPLET | | | | | dge, death occurr | | | | | | | | | |
| FUNER Within | 00 | 2 MEDIC | | On the basis of ax | amination | end/or investigation | n, In my o | pinion, de | eath occur | ed at the t | time, date | end place, and | due to the | ceuse(a) e | nd manner as stated. |
| Por fied | BE | 296. SIGNATURE AND TITLE C | OF CHITTINGS | MAA | . ~ | 2 | | | | NSE NUM | | | | | Ionth, Day, Year) |
| ₽₽2 ₹ | 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (1500, Print) James R. Mode Jr. 207 Brookes Ave Goithersburg mp 20877 31. Date Filep Maryin, Roy 2000 Jar. Registrar's signature | | | | | | | | | | | | | |
| | | James R. | MODE | 10 | 07 | Brook | est |)ve | G | oith | 1C.CS | bur. | mn | 20 | 277 |
| | | JAN 25 | 1996 | JE REGISTRA | R'S SIGNAT | Tuge Rordall | | | | | | 9 | | | |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | | | CERTIF | ICATE (| OF DI | EATH | F | REG. NO. | | | | |
|---------------|--|---|---------------------------------|----------------------------------|------------------------------|--|-----------------------------|----------------|---|----------------------|-------------------------------------|--------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF CEATH MONTH DAY YEAR MONTH DAY YEAR | | | | | | | | | 3. TIME OF OEATH | | | | |
| | MARY G. | | | | CORE | IN | | | January 23, 1996 | | | | 12:30 PM | |
| | 4. SOCIAL SECURITY NUMBER | 3 | | | . last birthday) | IF UNDER 1 YE | | INDER 24 HRS. | 7 DATE OF | BISTH | | | IPLACE (State or Foreign | |
| | 216-30-1638 | | 1 🗆 M 2 🖄 F | 73 | YRS. | MONTHS DA | WB HO | JRS MIN. | Feb. | 3,19 | 922 | Wes | st Virginia | |
| | 9e. FACILITY NAME (If not institution, give street end number) | | | | | | | | | | | c. COUNTY OF DEATH | | |
| OR | Memorial Hospital | | | | | Cumberland | | | | | Allegany | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| DIRECTOR | WV | | shire | | | Y, TOWN OR LOCATION | | | | LIMITS? | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| ا دِ | 10e. STREET AND NUMBER | | | | | | 101. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| FUNERAL | 437 Harmison Lane | | | | | | 26757 | | | | U.S.A. | | | |
| <u> </u> | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO | | | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (S | | | | | | | | |
| | 1 Never Married 2 Merried FORCES? 1 YES 2 X | | | | X) NO | en, Puerto Rica ly: | n, etc.) | k, White, etc. | | | | | | |
| B | 3 X Widowed 4 Divorce | ed | | | | | | | | | | | "White | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUA (Give kind of work of | | | | | | PATION og most of | working | 16b. KII | ND OF BUS | SINESS/IN | DUSTRY | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | | | | life. Do NOT use retired.) | | | | | | | | | |
| MP | N/A | | | | Home Maker | | | | | Hon | | | | |
| | 17. FATHER'S NAME (First, Midd Lewis A | - | ith | | | | 18. F | MOTHER'S N | ME (First, Midd Brad | ford | Sumame) | | | |
| BE | | - | LCII | | | | | | | | | | | |
| ဥ | 190. INFORMANT'S NAME (Type Beatrice | | | | 437 H | armisc | neet end N | ine, I | Route Number, | WV or Jow | n. State Z | 570 | | |
| | | | | | | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION | 3 🗆 Remo | val from State | | CEANDDATE | | | | 1996 | | | City or To | WV State | |
| | | TX Burlat 2 Cremetton 3 Removed from State Comparison of Chemettery Property Property | | | | | | | | | | | WV | |
| - 1 | | 00 | mas | | _ | | | | | | | | | |
| | 230 East Main St., Romney, WV 26757 | | | | | | | | | | | | | |
| | 23. PART I. Enter the disc shock, or has | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, ahock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| ı | IMMEDIATE CAUSE (Final | | | | | | | | | | Interval Between Onset and Dasth | | | |
| | disease or condition s. Acute Anterior Wall | | | | | | Myocardial Infarction 1 Day | | | | | | 1 Day | |
| | The state of the s | | DUE 10 (0 | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 1.0 | | |
| z | Diabetes Mellitus | | | | | | | | | | 10 Years | | | |
| CERTIFICATION | Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or Injury | | DUE TO (O | B 40 4 00 | IOFOLIENOE D | | | | | | | | | |
| | thet initiated events resulting in desth) LAST | - 1 | 002 10 (0 | H AS A CUI | ISEOUENCE D | -): | | | | | | | | |
| 5 | | d | | | | | | | - | | | | | |
| | PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. | | | | | | | | Part I. 24 | | | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | |
| EDICAL | | | | | | | | | | PERFORMED? | | | COMPLETION OF CAUSE | |
| MED | | | | | | | | | | | | OF DEATH? | | |
| - | DID TOBACCO US | E CONTR | IBUTE TO CAU | SE OF D | EATH Y | S NC | D | JNCERTAI | N 🗆 | | | | 0 - 2 - 0 | |
| Ž | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | | | | |
| Sic | EXAMINER? | | HOSPITAL: | ER/Outpatier | r 3 🗆 DOA | OTHER: | Home 5 | Raeldence | 8 Other (S | pec/fy) | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 26a. DATE OF IN (Month, Day, | | 26b. TIN | | c. INJURY | | 28d. DESCR | | NJURY O | CUREO | | |
| | 1 Netural 5 Pe | ending vestigation | (WORLD, Day, | rear) | 1145 | | WORK? | 2 NO | | | | | | |
| D BY | 2 Cutatés | | | t home, ferm, | m, street, fectory, office 2 | | | | 281. LOCATION (Street and Number or Rural Route Number, | | | | | |
| 핃 | | Building, etc. (Specify) | | | | | | | | City or Town, State) | | | | |
| ٦ | 290. CERTIFIER | | | | | | | | | | | | | |
| COMPLETE | anal and | | | | | | | | | | | | | |
| | 296. SIGNATURE AND TITLE O | | | | | | | . LICENSE NU | | | | | | |
| 8 | | | | M | D | | | D 2337 | | | 100 | | (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF F | PERSON WHO | COMPLETED CAUSE | OF DEATH | (ITEM 27) /7~~ | . Print) | | v 2331 | T | | Ja | nuar | y 25 1996 | |
| ĺ | | | nson Heig | | | | C | umb c = 1 | and W | m o | 1500 | | | |
| | 31. DATE FILED (Month, Day, Ye | arl | 32. AEGISTRAR | S SIGNATUR | RE | r brag | ٠, ٠ | umberl | and, M | W Z | 1002 | | - | |
| | 31. DATE FILED MONTH DAY, YO | 01996 | Jahr d'as | voluer | Carlette | | | | | | | | | |
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DNMH-1S Rev 1/89

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | BALTIMORE, MARYLAND 21215-0020 |
|---|--|
| (TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | s after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Debt. of Health and Mental Hygiene prior to bunial, cremation, or removal. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |

TO BE COMPLETED BY FUNERAL DIRECTOR

| FOR STATE REGISTRAR | | STATE OF MAR | | | | | EALTH AND DEATH | MENTA | L HYGIENE | | | |
|--|--------------------------------------|---|--------------------------------------|-------------------|--------------------------|----------------|--|-------------------|-------------------------------------|-------------|------------------------------------|---|
| t. DECEDENT'S NAME (First, GEORGE R | | CONNOR | | | | | | | of DEATH | , 199 | | 6:45 A |
| 4. SOCIAL SECURITY NUMB 173-28-359 | | SEX 6. A | GE (In yrs. lest | birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Month | OF BIRTH Day, (bar) 22, 1 | .936 | Country) | PA |
| sa. FACILITY NAME (If not in: 12005 MUL | BERRY A | | | | | | R LOCATION OF D | EATH | | 9c. COUNT | LEGAL | |
| RESIDENCE OF DEC | 10b. COUNTY Alle | gany | | | у, томи с | | | | | | | Dd. INSIDE CITY LIMITS? TYES 2 1 NO |
| 10e. STREET AND NUMBER | | | | | | 101. | 21502 | | | 10g. CITIZI | EN OF WH | AT COUNTRY? |
| 12005 Mul 11. MARITAL STATUS 1 Never Married 2 (X 3 Wildowed 4 Divo | Married 12 | WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O | ES 2 N | MED O | | It yes, spe | ENDENT OF NISPA celfy Cuben, Mexico 2 X ND Special | n, Puerto I | | | 14. RACE - Block, \ Specify: | - American Indian, White, etc. |
| (Specify only Elementary/Secondary (0 | EDENT'S EDUCATI highest grade con | ON opleted) college (1-4 or 5+) | (Gi | Do NOT us | vork done e retired.) | during mod | st of working | 16b | KIND OF BUS | | | |
| 12 | | | I | orme | er En | ub Jo | | | | an Dr | ive-/ | Away |
| 17. FATHER'S NAME (First, M. | | | | | | | 18. MOTNER'S NA | | | | | |
| George | D. Conr | or | 1 | | | | | | Steelm | _ | | |
| | | | | | | | nd Number or Rural | | | | _ | 1500 |
| Arlene J. | | | | | | | ry Avenu | - | | | | 21502 |
| 20a METHOD OF DISPOSITI | | trom State | 20b. PLACE A cometery, cre St. | matory or of | ther place! | | ery | 01/ | | mber | | |
| 21. SIGNATORE OF FUNERA | SERVICE LICEN | Mar | rel | 4 | 22. | Scar | pelli F perland, | unera | al Home 21502 | | | |
| 23. PANY 1. Enter the di shock, or he IMMEDIATE CAUSE (Fir disease or condition resulting in daeth) | eart fallure. Lis | epilications that cause of Ends. | | | | | nyoce | | | *** | est, | Approximata interval Between Onset and Death |
| Sequentially list condition in any, leading to immecause. Enter UNDERLY! CAUSE (Disesse or injusted initiated events resulting in death) LAS | diata ING Iry c | DUE TO (OR A | | DUENCE OF | F): | | | | | , | | |
| | ATIC | FAILUR | ٤ | | | | | | 24a. WAS AN PERFOR | MED? | o o | VERE AUTOPSY FINDINGS VAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 ND |
| DID TOBACCO U | | SUTE TO CAUSE | | TH YE | | | UNCERTAI | N 🗆 | | | | |
| 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO | H | OSPITAL: | | ./ | OTHE | R: | | • 🗆 | | | | |
| 27. MANNER OF DEATH | | 28s. DATE OF INJU | | 28b. TIM | | 28c. INJ | e 5 🗆 Residence | _ | SCRIBE NOW IF | LIURY OCC | URED | |
| 1 Natural 5 | Pending Investigation | (Month, Day, Ye | er) | INJ | M | 1 🗆 1 | RK? /ES 2 ND | | | | | |
| | Could not be determined | 28e. PLACE OF INJ building, atc. (| (Specify) | me, farm, : | ntree1, fac | tory, offic | | | CATION (Street a or Town, State) | nd Number o | or Rural Rou | ite Number, |
| CONTROL ONLY | | N: To the best of my k | | | | | | | | | | and menner as stated. |
| 29b. SIGNATURE AND TITLE | 900 | agery) | m | | | | 29c. LICENSE NU D22181 | MBER | | 29d. DATE | Jan. | Aonth. Day, Year) 251996 |
| 30. NAME AND ADDRESS OF | ner, M. | D., Bisho | p Wals | sh Dr | ive; | Cur | mberland | , MD | 21502 | 2 | | |
| 31. DATE FILED (Month, Day, | 5 1996 | 32. BEGISTRAR'S | | الفاد | | | | | | | | |

see Francisco All Ayren

anended # 7, 1/25/96, M&S, allegang Co.
Please Type or Print in Black Indelible Ink. Assure All Copies Are Land 664 State of Maryland / Department of Health and Mental Hygiene 96 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 5:35 PM. 19201 96 orlett /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Crofton Convaloscent Center roftun if Under 1 Year if Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1□M 25 F Months Days Hours 88 Yrs. 220-44-223 Director Wheeling W. VA Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1X Yas 2 No Allegany Maryland Cumberland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 5 234 825 Shawnee Ave. Pages 1 and 2 should be liled within 72 hours after death nent of Health and Mental Hygiene.
Int: If item 27 Ie marked other than "natural", or items 23. Funeral 21502 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 11. Merital Status 14. Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 Marriad 1 ☐ Yes 2 No by Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Church 12 Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Robert R. Carr Elizabeth (Bradley± 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) I of Health a If Item 27 le or other tra M. Elizabeth Blose 2820 Fleetwood Ave., Baltimore, MD 21214 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Department of Important: If it any Injury or conce. 1 Buriel 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Rural Valley Cem. 1/26/96 Rural Valley, PA 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** Immediete Cause (Finel disaasa or condition resulting in deeth) /Medical Examiner es e consequence of) Examine attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Couse (Disease or Injury that Initiated events resulting in death) Last Physician/Medicai Due to (or as a consequence of) signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Y00 2 No 3 Probably 4 Unknown Ď 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an eutopay performed? Completed certificata has rector, page 2: 1 ☐ Yes 1 ☐ Yes 2 ☐ No director. Be 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Beath 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Netural after death. 1 ☐ Yes 2 ☐ No 2 Accident tha 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) in by 4 Homicide pellil

Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours a

Baltimore, Maryland 21215-0020

within 24 hou To the Funer completely fill \$ 0

State Registrar

31. Dete filed (Month, Dey, Year)

29a. Certifier

29b. Signature

cause of deeth (Item 23e) (Type, Print) 32. Registrer's Signature

Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and piaca, and due to the ceuae(s) and menner as steted.

2 Medical Examinar: On tha bests of examination and/or invastigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

29c. Licansa number

29d. Date signed (Month, Day, Year)

) Cryton Catr (rytom md.

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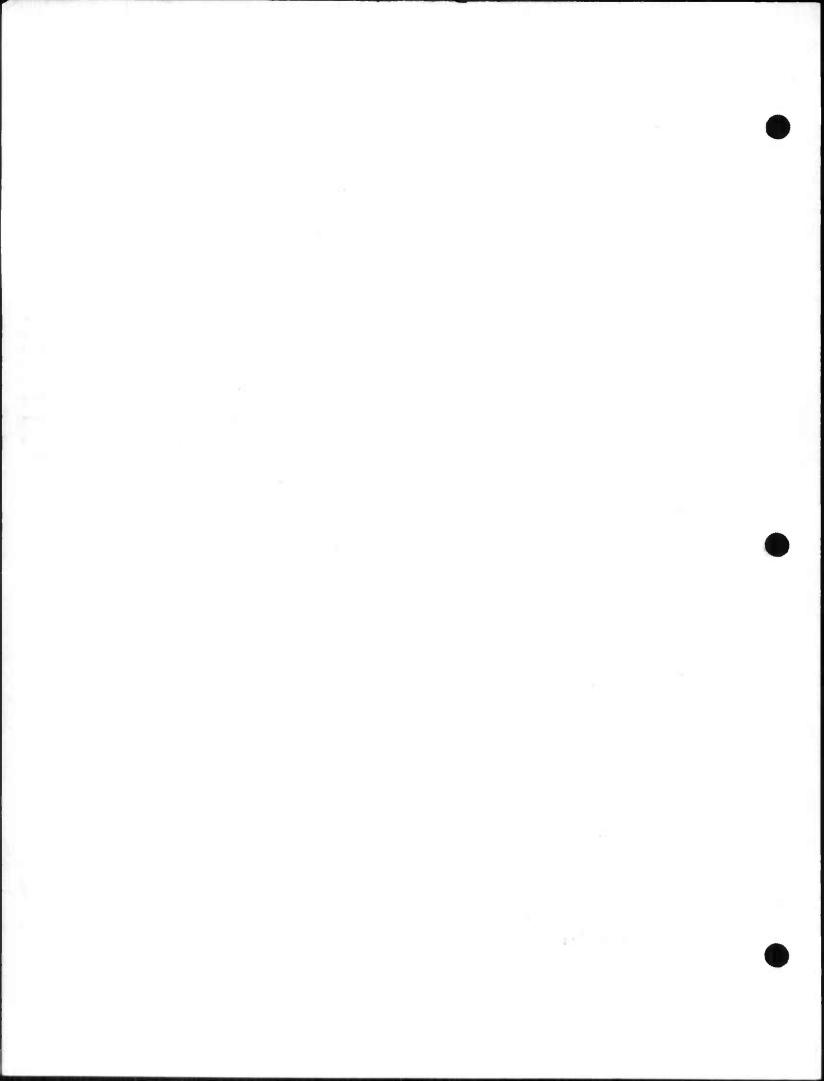
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH 05:30 YEAR PAULINE **VIRGINIA COWAN** A M JANUARY 1996 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH Jan 14 HOURS 1 M 2 TXF Maryland 61 YRS. 233-48-6791 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Allegany Sacred Heart Hospital Cumberland RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNT 10d. INSIDE CITY Maryland Allegany Westernport 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 27701 Clayton Ave. 21562 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 NO Specify В 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Dietary Dept. Employee Nursing Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Jesse Wolfe Ollie Malcolm BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Emma Brashear 100 Clayton Ave. Westernport, Md. 21562 20e. METHOD OF DISPOSITION
1 A Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - Cify or Town, Stata Bloomington Cemetery 1-26-96 Bloomington, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Boal Funeral Home 111 Church St. Westernport, Md. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate interval Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition _______ reaulting in death) HRUNIC OBSTRUCTIVE PULMONARY DISERSE 25YEARS DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO CONGESTIVE HEART FAILURE COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🔀 NO 🗌 UNCERTAIN 🗎 PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 Nursing Home 5 Recidence 6 Other (Specify) 1 | YES 2 | NO 1) Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO В 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 296, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE JANUARY 23, 1996 Astan DOCTOR 2

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 902 Seton 32. REGISTRAR'S SIGNATURE

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JAN 2 5 19



FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | ALGISTAAN | | CE | HILL | JAIL | JE DEATH | | REG. NO | • | | |
|---|--------------|--|-------------------------|------------------|--|-----------------------------|---|---------------|-------------------------------------|---------------------|-------------|--|
| | | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DAT | E OF OEATH | AV | YEAR 3. | . TIME OF DEATH |
| | | Viola Revnold | Revnolds Custer | | | | | | | | | 4:45 A M |
| | | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. last | | IF UNDER 1 YE | | s. 7. DAT | E OF BIRTH | | . BIRTHPL | ACE (State or Foreign |
| - | | 200-28-8706 | 1 D M 2 X X F 8 | 38 | YRS. | ONTHS DA | AYS HOURS MIN. (Month, Dey, Year) Country) Oct 12,1907 Maryland | | | | land | |
| should | | 9a. FACILITY NAME (If not institution, give s | reet and number) | | 9 | Pb. CITY, TO | WN OR LOCATION O | | 0 12/13 | 9c. COUNTY OF OEATH | | |
| 6.3 | E . | Goodwill Mennonit | Home | | | | tsville | | | | | |
| 1. 2. | DIRECTOR | RESIDENCE OF DECEDENT | - Home | | | GLaii | csviile | | | Garrett | | |
| Sadi | H. | 10a. STATE 10b. COUNTY | | | 10c, CITY, | TOWN OR LO | CATION | | | | 10 | Od. INSIDE CITY |
| &_ == | <u>a</u> | Pennsylvania Cam | oria | | · | Johns | town | | | | ډ ا | LIMITS? |
| permit. Pages | 4 | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | _ | | 10g, CITIZE | | AT COUNTRY? |
| 15th | 8 | 921 Harlan Avenue | | | | | 1590 | 01 | | | USA | |
| TAND ZIZIS-0020 the hospital or attending physician. detached for use as the burial-transit once. | FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVI | ER IN U.S. ARI | 4EO | 13 WAS | DECENDENT OF HIS | PANIC ODIC | IN2 (Canally Van | | | A 2011 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A 101 A |
| 5-0020 nding physic is the burial | | 1 Never Married 2 Married | FORCES? 1 1 | rES 2 N | 0 | If yes | , specify Cuben, Me | xican, Puart | Rican, etc.) | OF NO | | - American Indian, White, etc. |
| E E | B | 2√X Widowed 4 □ Divorced | IF TES, GIVE HAR O | H UAIES | | ויי | YES 2 XXIO SE | ecity: | | | Specify: | h |
| aftend attend Se 25 | ETED | 15. DECEDENT'S EDUC | ATION | 16a. DEC | EDENT'S US | SUAL OCCUP | PATION | 10 | Sb. KIND OF BUS | SINESS/INDIA | whit | ce |
| of or att | | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Gh | e kind of wor. Do NOT use r | rk done during retired.) | most of working | | | | | |
| NO hospital ached fi | 립 | 12 th | Conege (I-4 or 5+) | Ot.77 | ner/or | oorat | 250 | ١, | Dr | + a O. | _ | |
| he hospit detached | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Owi | IEL/O | Jeraci | | | Typewri | |). | |
| 8 6 6 E | | Albert Swauger | | | | | | | | Surname) | | |
| | BE | 19a. INFORMANT'S NAME (Type/Print) | 401 | MAII INC. AT | DDD500 (0) | Bertha | | | | | | |
| 2 - 0 = | 일 | James D. Reynolds | | | | | | | | | | ` |
| may be | | 20a. METHOD OF DISPOSITION | | | | ge Dr., H | ampro | | | | | |
| must | | 1-X Burial 2 ☐ Cremation 3 ☐ Remo | DISPOSITION r place) | | 1 | | CATION CI | y or Town, | , State | | | |
| 2 2 2 | | T☐ Donation 5 ☐ Other (Specify) | Lawr | | Jan 2 | | 6 Joh | nstowr | 1, PA | <u> </u> | | |
| death. Pag tuneral di i. examiner | H | 22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A., P.O | | | | | | | | | | D 075 |
| | | al Lyw () | Leurna | w | | | | | | | | |
| ours after d d in by the or removal. | \Box | 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| hours or r | | interval E IMMEDIATE CAUSE Final Onset an | | | | | | | | | | |
| 15 mm mm 12 | | disease or condition | | | | | | | | | | |
| completely ial. cremati, | 1 1 | | | | | | | | | | | one day. |
| a in a | _ | | | | | | | | | | | |
| h certificate be executed shding physician and con Hygiene prior to burial. | ERTIFICATION | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | U |
| ysician prior 1 | ¥ | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| ficate b physici ne prior | 윤 | CAUSE (Disease or injury that initiated events | DUE TO (OR A | AS A CONSEQ | JENCE OF1: | | | | | | | |
| eath certification attending attending y, or oth | ᇤ | resulting in deeth) LAST | | | | | | | | | | |
| | 8 | | | | | | | | | | | 1 |
| = - = | 님 | PART II. Other aignificent conditions | contributing to deat | h but not re | resulting in the underlying cause given in | | | | n Part I. 24a. WAS AN AUTOPSY | | | ERE AUTOPSY FINDINGS |
| that the ed by the and in | EDICAL | Severe H | 12 him | us | 120 | men - | tia | | PERFOR | | | MILABLE PRIOR TO OMPLETION OF CAUSE |
| S deal c | | | | | | | | | ' 'ES 2 | P. NO | | DEATH? |
| been t. of b | Σ. | DID TOBACCO USE CONTR | IBUTE TO CAUSE | OF DEAT | H YES | Пио | UNCERT. | | | | 111 | YES 2 NO |
| he law requires been a Dept. of h | IAN: | 25. WAS CASE REFERRED TO MEDICAL | IDOIL TO CAUSE | | OF DEATH | | | All A | <u> </u> | | | |
| SICIAN: The certificate h the State I | SICI | EXAMINER? | HOSPITAL: | | 0 | THER: | | | | | | |
| certific the | HX | 27. MANNER OF DEATH | 28e. DATE OF INJUI | | 28b. TIME O | | fome 5 Residen | - | | | | |
| 사람들 등 | 0 | 1 Natural 5 Pending | (Month, Day, Yea | ar) | INJUR | Y | WORK? | 280. 08 | SCRIBE HOW IF | NJURY OCCUP | IEO | |
| After death | BY | 2 Accident Investigation | 28e. PLACE OF INJ | IIIV - At hom | a form of the | | | - | | | | |
| TTEND TOR: / after d | | 3 Suicide 6 Could not be 4 Homicide determined | building, etc. (S | Specify) | ru, sarim, atru- | et, inctory, c | писе | | CATION (Street a or Town, State) | nd Number or | Rural Route | e Number, |
| OR ATTEN DIRECTOR: hours after item 28 is | i i | 20- CERVICIER | | | _ | | | | | | | |
| 보 보전 # | COMPLE | 29e. CERTIFIER (Check only one) | | | | | | | | | | |
| HOSPITAL FUNERAL Within 72 TANT: If | Ö | 2 MEDICAL EXAMINER | On the basis of examina | ation and/or in | veatigatien, i | in my opi nio | h, death occured at | the time, dat | a and place, and | d due to the c | ause(a) an | id menner as stated. |
| THE FU filed wil | ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 /1 | 2 | 0 | 11 | 29c. LICENSE I | NUMBER | T | 29d. DATE S | IGNEO (MC | onth, Day, Year) |
| TO THE HOSPIT TO THE FUNER be filed within I | 8 | | ١ ' |)/ | | m | D: | 40- | 70 | D . | 10 | 19 1996 |
| / [] | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE | MATH (ITEM | 27) (Type, Pri | | 1 0 | | - | 09 | 1 | 11111 |
| 10 | | (dame | VE T | Seit- | 7.01 | mi | an | to. | 2110 | mi | | |
| 00 | | 31. OATE PIL PLANTING TO YOUR TO | VASCOLO BARRIES | IGHATURAL. | <u>B</u> | | U-14 | 101 | 116 | 111 | | |
| | | | 9 | | - | | | | | | | 1 |

DIVISION OF VITAL RECORDS. P.O. BOX 68760

3.1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03667

| | | | | | | Certifica | te of | Death | | Reg. No. | O | 000 | 0 1 |
|------------|--|---|---|---|--------------------|------------------------------------|-------------------|-----------------------------|---|------------------------------|-------------|-----------------------|------------|
| | | | 1. Decedant's Name (First, Middla, | Last) | | | | | 2. Data of D | eeth | V | 3. Tima o | f Death |
| | Physici /Medi | | TIMOTHY | CHARLES | | Cr | awfo | ord | Jan. | 30 Dey 199 | 6 Year | 10:3 | 4 AM |
| | Examir | | 4a. Fscility Nama (If not institution, | giva street end number) | | | | 4b. City, Town, | or Location of Dee | | | h | |
| | manuiiii | ••• | The Memorial | Hospital | at Ea | ston | | East | con | Ta | 1bot | t | |
| | Funeral Director | | | | (In yrs. last bii | | er 1 Yaar Deys | | Hrs. 8. Dete of B | irth lay, Year) 20,195 | 9. Birth | hplace (State ountry) | or Foreign |
| | _ | | Usuel Rasidanca of Decedant | | 31 | | | | DEC. | 20,193 | O MI | EM OFI | COLI |
| | Mand Mand | | 10a. Stata 10b. County | | 10c. City, Tow | n or Location | | | | | | 10d. Inside C | Ity Limits |
| | Me. | ō | MD TA | LBOT | | EASTON | | | | | | 1 🗆 Yes | 2 No |
| | 28e | Director | 10e. Street and Number | прот | | | ip Coda | | | 10g, Citizan of | What Co | | |
| | 23e or | | 27170 ENNIS | KILLEN RD | | | | 21601 | | | SA | , | |
| | ep L | Funeral | 11. Meritel Status | 12. Was Decedent 6 Armed Forcas? | Ever in U,S. | 13. Wes Dace | edant of | Hispanic Origin' | ? (Specify Yes or Nuarto Rican, atc.) | | ce - Amar | rican Indian, | |
| 020 | 2 should be filed within 72 hours after death with the Meryland and Meniel Hygiene. Is merked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Examples must be incitted at | by | 1 Wevar Merried 2 Marrie 3 Widowed 4 Divorced | d 1 ☐ Yes 2 ☑ N If Yas, Giva Year or Datas: | lo | 1 ☐ Yas | | | | Specia | | WHITE | |
| 21215-0020 | natura natura | Completed | 15. Decedant's (Specify only highest | Education greda complatad) | 16a | Decedent's Usi (Giva kind of w | ork done | during most of | working | 16b. Kind of B | Jusiness/I | ndustry | |
| 7 | E 2 9 A | ш | Elemantary/Secondary (0-12) | College (1-4or 5 | +) | Ilfa. DO NOT | | • | | CON | cmbr. | CTION | |
| 7 | Her I | | 11 17. Fsther's Nama (First, Middla, La | not) | | ELECTR | ICI | T | About Alidate | | | CITOR | <u> </u> |
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| aryland | 1 Mer | 10 | JAMES ALVIN | | | | | | | | | | |
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| a a | permit. Peges 1 end Department of Heelt Important: If Item 2: any Injury or other: once. | | 20e. Mathod of Disposition | | | f Disposition (Nerry, cramatory or | | aca) | Data | 20c. Location | - City or T | Fown, Stata | |
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| altimore, | pemit. Peges Department of I Important: If ite any injury or of | | 21. Signature of Funaral Sagvice Lie | | | | | ess of Fecility | 1 | | | | |
| ä | Depar Impor | | MEIR | Ti | CES/ | NEWN | AM I | UNERA | L HOME, | P.A. | | | |
| | | Н | 220 Parts Solar the disease or | mour | the death Co. | | | | | | N, M | Approximet | |
| | | | shock, or haert failura. List only one causa on aach line. | | | | | | | | | | |
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| | /Medical Examiner | | Immediate Ceuse (Final disaase or condition rasulting in daeth) | a Gram | Negati | ve Sep | sis | | | | | 48 ho | urs |
| | | | rasulting in daeth) | | Due to (or as a | consequance of |): | | | | | | |
| | D : | lne | | Hepatic Failure | | | | | | | | | |
| 'n | death certificate be executed e attending physician and ed for use as the burlet-trensit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | | | | | | | | | |
| 68760 | e be | edical | that initieted evants | c | Due to for es e | consequence of) | | | - | | | | |
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| o i | v requires that the de been signed by the a should be deteched | Physician | Part II. Other significant conditions | contributing to death bu | t not rasulting ii | n tha undarlying | ivan in Part I. | | 23b. Dfd tobacco use contribute to the cause of o | | | | |
| J. | thet dete | 4 P | Alcoholism | | | | | | 10 | Yee 2 XNo | 3 Pr | obably 4 | Unknown |
| Hecords, | lew requires that the ass been signed by th s 2 should be detache | d by | | | | | | | 240 1410 | s an autopsy | 24b \ | Ware sutopsy | findings |
| ō | need | Completed | | | | | | | | ormed? | 8 | vailable prior to | to |
| e . | S S C | ldu | | | | | | | | | 0 | of death? | |
| = 1 | Pa as | Sor | | | | | | | 1 🗆 | Yas 20 No | 1 | Yes 2 | No |
| VITA | Physician: The this certificate and director, pag | Be | 25. Wes casa refarred to medical axaminar? | | | | | 26. Place of | Death (Check only | ona) | | | |
| 0 | Physic this ce al dire | 0 | 1 Yes 2 No | Hospital: X Inpatia | nt 2 ER/Ou | itpatient 3 D | OA O | har: 4 Nursin | ng Home 5 Ras | Idanca 6 Ott | her (Spec | cify) | |
| ס בי | After fune | Certification: | 27. Mennar of Deeth 1 Natural 5 Pending 2 Accidant invastigat | 28a. Dete of Injur (Month, Day | Year) 28b. 1 | Fima of njury M | 28c. Inju Wo | ryat ork?]Yes 2 □ No | 28d. Dascribe | how injury occur | rred | | |
| DIVISION | Attend or death octor: by the | fica | 3 ☐ Suicida 6 ☐ Could no | be con Diagonal Initia | rv - At homa, fa | rm. street, facto | rv. office | | 28f. Location | (Street and Num | ber or Ru | ral Routa Num | nber. |
| | Dire Dire | erti | 4 ☐ Homicida detarmine | building, atc | (Specify) | ,, | ,, | | | wn, Steta) | | | |
| | ours fille | | 29a, Certifler X Certifying | Physicism: To the best o | mv knowledne | death occurred | 1 at the ti | ima data and ni | lace, and due to the | cause(s) and m | ennor os | etated | |
| | To the Hospital or within 24 hours aftur To the Funeral Dir completely filled in | edical | (Check only 2 Medical Ex | aminer: On the basis of and mannar sta | axamination an | d/or invastigation | n, in my | opinion, daath o | occurred at tha tima | , data and plece, | end due | to the cause(| 5) |
| 1 | vithin To the comple | M | 29b. Signatura end titla of certifier | | | 29 | c. Licen | se number | | 29d. Dete signe | ed (Month | n, Day, Year) | |
| | ->-0 | | Place 00. | MASS | 21.1 | | D 3 | 8990 | | Jan. 3 | 1. 1 | 996 | |
| | | - | 20 Name and address | W. W 110 | more | e any. | | | | | | | |
| | | 30. Nama and addrass of person who completed causa of daath (Neghn 23a) (Type, Print) Charles E. DiNapoli MD 404 Marvel Ct. East | | | | | | | ton, MD | 21601 | | | |
| | | | 31. Dete filed (Month, Dey, Year) | | | marvel | CL | • EdS | COII, IND | ~1001 | | | |
| | Sta Registr | | FEB 01 | | r's Signatura | Randall | | | | | | | |
| | Registr | ai | , LD 01 | 1220 | | | | | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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| | | | | | | Cer | tificate of | Death | | | Reg. No. | | 00000 | |
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| | | | 1. Decedent's Name (First, Middle, La | est) | | | | | - | 2. Date of De | | | 3. Time of Death | |
| | Physic | | Alisia | Leno | ra | | COPPER | | | Jan 22 96 | | | 5:10PM | |
| | /Medi | | 4a. Fecility Neme (If not institution, gir | | | | | 4b City Toy | wn orloc | ation of Deeth | - | y of Death | J. TUPM | |
| | Exami | ner | The state of the s | | | eton | | | | | | | | |
| - | | | The Memorial Hospital at Easton Easto 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. | | | | | | | 8. Dete of Birt | | albot | | |
| | Funeral | | | 1□M 2⊠F | | | | | | | lay, Year) Country) | | | |
| ч | Director | | Usuei Residence of Decedent | | | 32 | | | | may o, | 6, 1963 Maryland | | | |
| | and | | 10a. Stete 10b. County | | 10c. City, | Town or Loc | cation | | | | | 1 | 0d. Inside City Limits | |
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| | the h | Director | Maryland Talbot 10a, Street and Number | | East | on | 104 7:- 0-4- | | | | 10- 011 | 145 0 | 11 | |
| | With Mile | | | 1 | | | 10f. Zip Code | | | | 10g. Citizen of | what Cour | ntry? | |
| | ath 23 | rai | 9888 Klondike Ro | | | | 21601 | | | | USA | | | |
| | be filed within 72 hours effer death with the Meryland ntal thygiene. Id other then "natural", or flems 23s or 28s-f show event, the Medical Exeminer must be nothered. | Funeral | 11. Maritei Stetus | 12. Was Deced | dent Ever in U.S. Çeş? | 13. V | Vas Decedent of I Yes, specify Cub | Hispanic Orig en, Mexican | gin? (Spec , Puerto F | cify Yes or No- lican, etc.) | | ca - Americack, White, | | |
| 20 | S of | by F | 1 Never Married 2 Merried | if Yes, Give | | 1 | ☐ Yes 2 No | Specify: | | | Speci | fv: 7.1 | | |
| 21215-0020 | ural" | Q P | 3 ☐ Widowed 4 █ Divorced | Year or De | | | Λ | | | | | , BT | ack | |
| 5 | nat rhat | Completed | 15. Decedent's E (Specify only highest gro | ducetion ade com <i>pleted)</i> | | (Give I | ent's Usual Occu kind of work done | during most | of workin | g | 16b. Kind of E | Business/In | dustry | |
| 12 | within 7 ene. then "r | d L | Elementary/Secondary (0-12) | Coilege (1- | | _ | OO NOT use retire | id) | | 1 | | | | |
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| E | tal tal | Be | 17. Father's Name (First, Middle, Last | | | | | | | | Malden Suma | me) | | |
| K | should and Men marke | 2 | Charles Britting | nam | | | | Bert | tina | Copper | | | | |
| Maryland | CI 6 | | 19e. Informant's Name/Relationship | Type, Print) | | 19b. Mailln | g Address (Stree | t an <i>d Numb</i> e | r or Rural | Route Number | er, City or Town | , State, Zip | Code) | |
| | Heelth Heelth John 27 I | | Bertina Copper | | | | 8 Klondi | ke Roa | id, E | aston, | Md. 21 | 601 | | |
| ore | T Per T | | 20a. Method of Disposition |]D | | e of Dispos | sition (Name of natory or other pla | ice) | 1 | Dete | 20c. Location | - City or To | own, State | |
| Ē | Pages nent of h int: If he | | 1 X Buriai 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | y) | Rich | nardso | n Cemet | ery | 1 | /27/96 | Easto | n, Md | | |
| Baltimore, | 고등문중 | | 21. Signature of Funeral Service Lice | | 22. | Neme end Addre | ess of Facility | у | | | | | | |
| 0 | Departing Shaper | | | | | | Bennie | Şmith | Fune | ral Hon | ne | | | |
| | _ | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | micetions that ca | used the death | | Easton, | | | | raet | | Approximate | |
| 68760, | certificete be axecuted ding physician end ise as the burial-transit | /Medical Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last | b. 8.0 | Due to (or a | s e consequ | uence of): | | | | | | | |
| s, P.O. Box | hat the death cer d by the attendin detached for use | by Physician/N | Part II. Other significant conditions of | 1- | | 44 | | ven in Part I. | | | obacco uss co | ontributs to | the cause of death? | |
| Vital Records, | aw requires been s | Completed t | Acute Re | na l | Jarle | ne | | | | | an autopsy med? | av | ere autopsy findings ailable prior to mpletion of ceuse death? | |
| Œ | 0 - 0 | E | | | | | | | | 101 | es EXNO | 1[| Yes 25 | |
| ta | ician: The | BeC | 25. Was cese referred to medicei | | | | | 28 Place | of Death | (Check only o | nel | | | |
| > | | To B | examiner? 1 ☐ Yes 2 2 10 | Hospital: | patient 2□EF | VOutpatient | 3□ DOA Ot | hor- | | | lence 6 Ot | har (Enacid | id. | |
| o | Physeral d | | 27. Menfler of Deeth | 28a. Dete of | injury 28 | Bb. Time of | 28c. Inju | | | | ow Injury occu | | 77 | |
| Division | Attending For death. ector: After by the funer | Certification: | 2 Accident 5 Pending investigation | | , Day Year) | injury | | rk? Yes 2∐N | No | | | | | |
| İSİ | dea ctor | fica | 3 Suicide 6 Could not b | | of Injury - At home | e. farm. stre | et, factory, offica | | 2 | 8f. Location (S | Street and Num | ber or Rura | I Route Number, | |
| S | or after Dire | ert | 4 Homicide | building | g, etc. (Specity) | 0, 10,111, 01,10 | ot, lastory, omea | | | City or Tou | | | | |
| | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun | edical C | 29e. Certifier (Check only one) Certifying Ph | ysicien: To the b niner: On the bas end making | is of examinetion | edge, deeth and/or inve | occurred at the ti estigation, in my o | me, date and opinion, deet | d piace, ar h occurre | nd due to the d d et the time, d | euse(s) and m | anner as s | tated. the ceuse(s) | |
| | To the To the comp | Me | 29b. Signature and title of certifier | Nes | ans | 6 | 29c. Licens | se number | 105 | - | 29d. Date sign | ed (Month, | 9ay, Year) | |
| | | 30. Name and address of person who completed ceuse of deeth (item 23a) (Type, Print) Michael Lees, M.D., 606 Dutchman's Lane, Easton, Maryland 21601 | | | | | | | | | | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) JAN 25 19 | | | | | | | | | | | |

31. DATE FILED (Month, Day, Year)

JAN 2 4 1996

32. DEGISTRAR'S SIGNATURE Tales Davilson Rardall

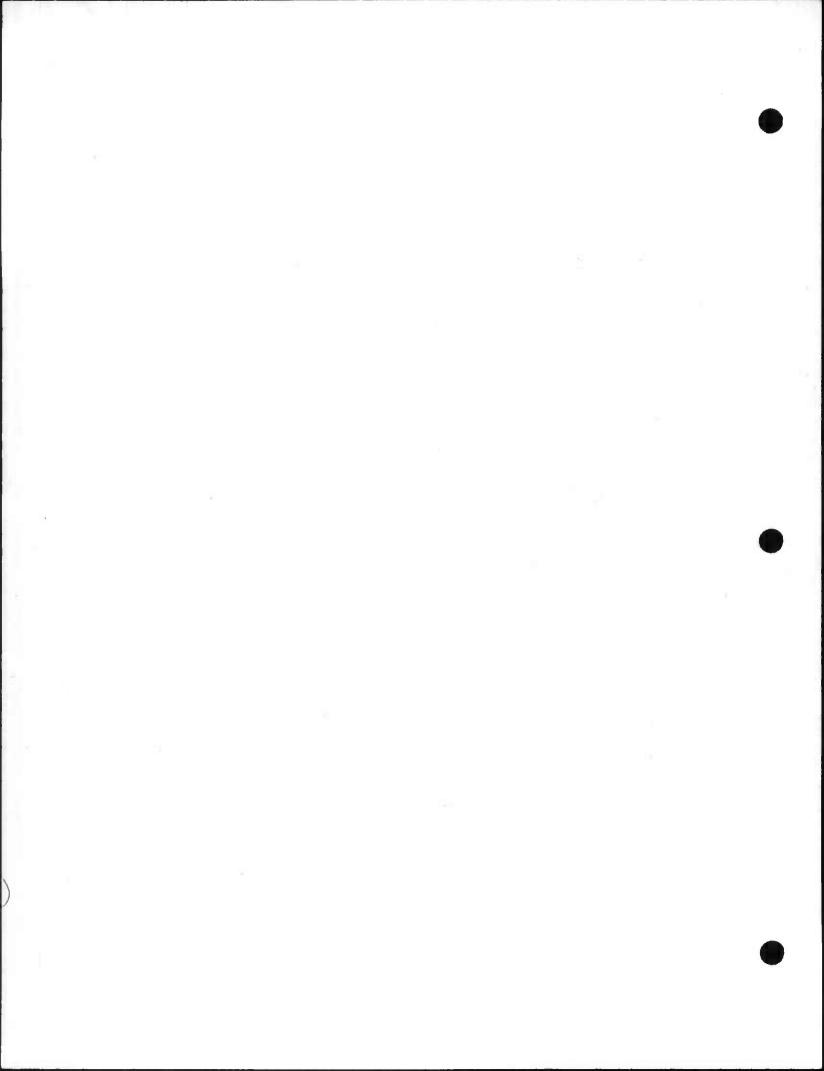
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IMPORTANT: If II

| physician. | burial-transit permit. Pages 1, 2, 3 sho | |
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| L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physic | UPRECIDES After this certificate has been signed by the attending permit. Pages 1, 2, 3 sho Processes, death, with the care of the control of the confidency of the confidency permit. Pages 1, 2, 3 sho | must be notified at once. |
| be executed within 24 hours after death. Pag | ian and completely filled in by the funeral di | thous and board with the State Dept. Or begin and western pything prior to builds, betterford, or territoria. Item 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once, |
| The law requires that the death certificate b | te has been signed by the attending physici | thous are used min the clare cept, or resent and wenter hybring prior to botter, usualistic the medical ex- |
| OR ATTENDING PHYSICIAN: | DIRECTOR: After this certificat | item 28 is marked, or ite |

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH JANUARY Ella B. Chase 18 2:15 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 M 2 TF 213-16-4765 85 YRS. Feb. 1910 Maryland 9a. FACILITY NAME (If not institution, give street and number 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dorchester General Hospital Cambridge Dorchester RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Linkwood 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3713 Ocean Gateway 21835 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: Specify: Black 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify Elementary/Secondary (0-12) College (1-4 or 5+) 7th Domestic Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Levin Baltimore BE Millie Jolley 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Hilda White 3028 Grantley Ave, Baltimore, Md. 20a, METHOD OF DISPOSITION
1 N Burtal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State tery, cremetory or other place)
Thompson Chapel Cemetery 1/25/96 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SAMPLE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home P.O. Box 1687, Easton, Md. 21601 23. PART i. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. Liet only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition FAILURE RESPIRATORY DAYS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DYSFINCTION VENTRICULAR CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate FAILURE cause. Enter UNDERLYING . CONGESTIVE HEART CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST HYPER TENSION PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? DIABETES 1 - YES 2 1 NO OF DEATH? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO X UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Rasidence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 8 Pending BY 1 VES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) ETED . 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Toury, State) 6 Could not be 4 Homicide datermined 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 96. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Michael a. Mostoce 18, 1996 -16609 DAWARY 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 2 MICHAEL A. MOSKEWICZ MD 503 BYEN STREET CAMBRIDGE MARYL



YEAR

3. TIME OF DEATN

REG. NO

2. DATE OF DEATN

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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COPEX CLARA 4:20 PM ALICE January 27 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Yea B. BIRTNPLACE (State or Foreign Country) HOURS 1 M 2 X F DAYS 90 577-09-8449 Virginia May 27, 1905 for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SALISBURY WICOMICO DIRECTOR PENINSULA REGIONAL MEDICAL CENTER RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Wicomico Salisbury 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER tof. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 212 Philip Morris Dr. 21801 USA by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puerto Rican, atc.)
t ☐ YES 2 ☒ NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED t4. RACE — American Indian, Black, Whita, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY Specify: 3 XWidowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) 핔 Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 11 0 Retail Industry notified at once, 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Richard Thomas Frances Dodson (unknown) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 James Cooper 704 Parkway Circle, Salisbury, MD 21801 pe 20s. METNOD OF DISPOSITION
1X Burlal 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 Donation 5 Other (Specify) Sunset Memorial Gardens Fredericksburg. 22. NAME AND ADDRESS OF FACILITY
Holloway Funeral Home examiner L SERVICE LICENSEI 501 Snow Hill Rd., Salisbury, MD 21801 medical 21 PART I. Enter the diseases, or complications the sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ahock, or heart failure. Liet only one 8 Onset and Death IMMEDIATE CAUSE (Finel the disease or condition reculting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury that Initieted events or other DUE TO (OR AS A CONSEQUENCE OF) reaulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item State FXAMINER? HOSPITAL:
11 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Nome 5 Residence 8 Other (Specify) the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, with 1 Natural 5 Pending м 1 YES 2 NO BY Investigation after death 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 28 is 3 Suicide 8 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTL be filed within 72 hours at IMPORTANT. If Item 2 29a. CERTIFIER
(Chack note)
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE reases D3074 96 : aury 223 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Benjamin Quincy + Locust Sts. 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) JAN 3 U 1996 5

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

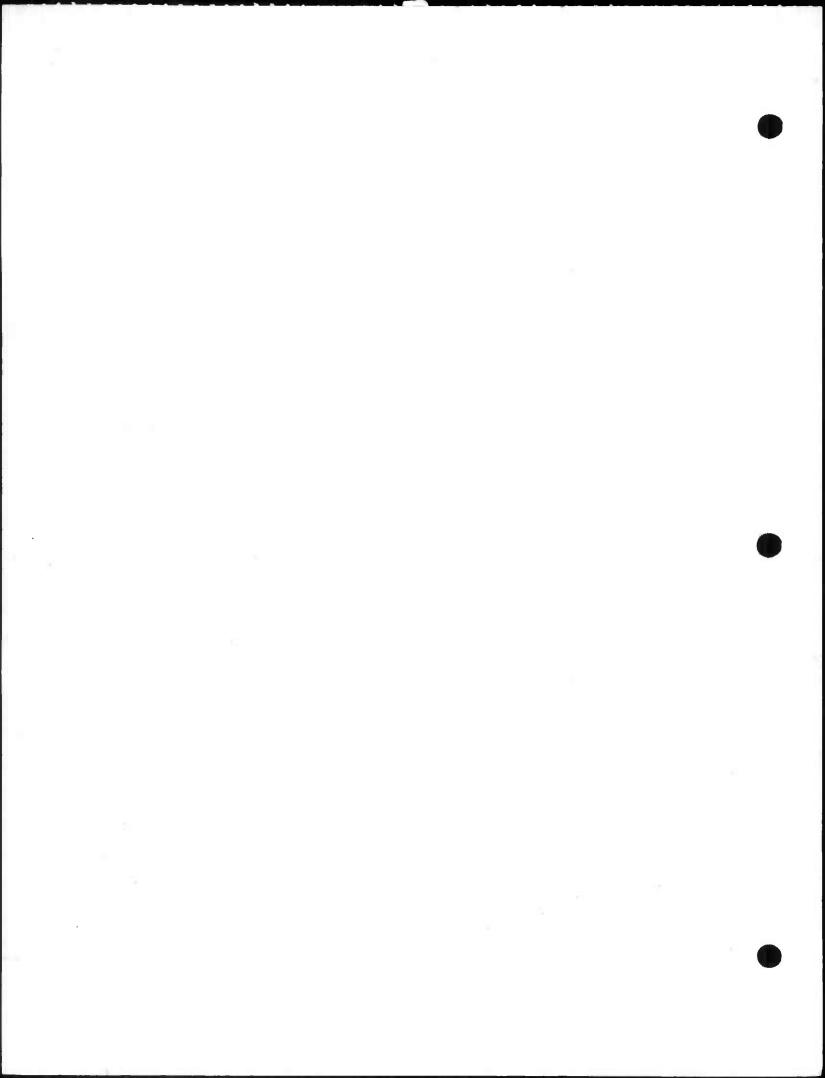
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| Il or attending physician. | for use as the burial-transit permit. Pages 1, 2, 3 should | | |
|---|--|--|--|
| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | 3. TIME OF DEATH | |
|------------------------------------|--|--|--|--|--|--|--|---|--|--|----------------------|--|--|
| | Harry Ray | Colli | son | | | | | | | | DAY Q | 96 | |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | 0 | | 11:00p M IPLACE (State or Foreign |
| | 222-24-0886 | | 1 XM 2 - F | 82 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Dey, Year) 10-17-13 | | Count | n) |
| | 9a. FACILITY NAME (If not in | | 21 | 02 | | 9h CITY | TOWN (| OR LOCATI | INTY OF D | ton, Md. | | | |
| Œ | Carolino Nu | reina | Uomo Tn | | | | | | | | | | |
| 6 | Caroline Nu | EDENT | nome, In | С, | | Denton Caroli | | | | | | | ne |
| DIRECTOR | 10e. STATE | 10b. COUNTY | | | 10c. CIT | Dc. CITY, TOWN OR LOCATION | | | | | | | 10d. INSIDE CITY |
| | De | Ke | nt | | На | rrin | etor |) | | | | | LIMITS? |
| AL | 10e, STREET AND NUMBER | | | | | | | | IZEN OF WHAT COUNTRY? | | | | |
| FUNERAL | 1832 Bro | | 19952 | | | | | | US | Δ | | | |
| 5 | 11. MARITAL STATUS | T EVER IN U.S. AR | ADMED 12 WAS DECEMBENT OF HISPANIC | | | | | | | 14. RACE | E — American Indian, | | |
| ВУ | 1 Never Married 2 3 Y Widowed 4 Divo | YES 2 X P | | | | | | | Speci | k, White, atc. | | | |
| | - 11 | | | | | | | | | | White | | |
| COMPLETED | 15. DEC (Specify only | (G | CEDENT'S | work done | CUPATIO | ON st of working | eg. | 16b, KIND OF BU | ISINESS/IN | DUSTRY | | | |
| Ë | Elementary/Secondary (0 | -12) | College (1-4 or 5 | +) life. | Do NOT us | se retired.) | | | | i | | | |
| M | 12 | | | F | Farmer | | | | | | cultu | re | |
| | 17. FATNER'S NAME (First, M | | | | | | | 18. MOTNER'S NAME (First, Middle, Meiden Surname) | | | | | |
| BE | Harry Col | | | | | | | Dor | a(A) | nderson) | | | |
| 2 | 19a. INFORMANT'S NAME (1 | | | | | | | Ploute Number, City or Tox | | | | | |
| | Wayne Coll | | | | | | | Rd. | Harringto | | | | |
| | 1 Geburial 2 Crematic | n 3 🗆 Ramo | oval from Stata | 20b. PLACE A cemetery, cre | matory or o | ther place) | - ' | me of | | DATE 20c. LO | OCATION — | City or To | wn, Stata |
| | 4 ☐ Donation 5 ☐ Other 21. BIGNATURE OF JUNERA | | ENGEE A | - Dento | n, C | emet | ery | D ADDRES | | | enton | . Ma | D.K. |
| | P | Q | 11 () | . \ | | | | | | 1000 | 12 7 | 0.00 | afend I |
| | 10mm | - 6.V | Well | ren | | M | EL | Vin | F | N. LIAK | e will | ta | ,20, |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory errest, ahock, or heart failure. Liet only one ceuse on each line. Approximate interval Between | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Fine) | | | | | | | | | | Onset and Death | | |
| | disease or condition | | | | | | | | | | 10000 | | |
| | | | DUE TO | OF AS A CONSEC | DUENCE OF | 7: | | | | | | | Icary |
| - 10 | | | | | | | | | | . / 1 | | | |
| N N | Sequentially list conditi | | | | | | | | | | | | |
| VTION | Sequentially list conditi | diate | ASC DUE TO | (OR AS A CONSEC | DUENCE OF | ጉ: | | | | | | | |
| CATION | If any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or inju | diate NG | DUE TO | (OR AS A CONSEC | | | | | | | | | / |
| ITIFICATION | If any, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or inju- that initiated events | diate NG ry | DUE TO | | | | | - | | | | | |
| CERTIFICATION | If any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or inju | diate NG ry | DUE TO | (OR AS A CONSEC | | | | | | | | | / |
| AL CERTIFICATION | If any, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or inju- that initiated events | diate NG ry | DUE TO | (OR AS A CONSEC | OUENCE OF | n the un | derlying | g ceuse g | piven in I | Pert I. 24a. WAS AF | AUTOPSY | 246. | WERE AUTOPSY FINDINGS |
| | If any, leading to immedicause. Enter UNDERLYI CAUSE (Disease or injusthat initiated events resulting in deeth) LAS | diate NG ry | DUE TO | (OR AS A CONSEC | OUENCE OF | n the un | derlyIng | ceuse g | liven in i | PERFO | RMEO? | 24b. | AWAILABLE PRIOR TO COMPLETION DF CAUSE |
| | If any, leading to immedicause. Enter UNDERLYI CAUSE (Disease or injusthat initiated events resulting in deeth) LAS | diate NG ry | DUE TO | (OR AS A CONSEC | OUENCE OF | n the un | derlyIng | ceuse g | given in i | | RMEO? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| MEDICAL | If any, leading to immedicates. Enter UNDERLY! CAUSE (Disease or injut that initiated events resulting in deeth) LAS | ont condition | DUE TO | (OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CON | esulting | n the un | trc | uliti | 3 | PERFO 1 TYES | RMEO? | 24b. | AWAILABLE PRIOR TO COMPLETION DF CAUSE |
| MEDICAL | If any, leading to immedicates. Enter UNDERLY! CAUSE (Disease or injuit that initiated events resulting in deeth) LAS PART II. Other eignification of the control of the co | ont condition SE CONTR | DUE TO | (OR AS A CONSECTION OF AS A CONSECTION OF DEA | esulting | n the un | 4tc | uliti | elven in i | PERFO 1 TYES | RMEO? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| MEDICAL | If any, leading to immediate any, leading to immediate and included an | ont condition SE CONTR | DUE TO | (OR AS A CONSECTION OF AS A CONS | esulting in the second | n the un S | HTC 10 D | UNC | ERTAIN | PERFO 1 TYES | RMEO? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| MEDICAL | If any, leading to immercause. Enter UNDERLY CAUSE (Disease or Injuthat initiated events resulting in deeth) LAS PART II. Other eignification of the control of the contro | ont condition SE CONTR | DUE TO DUE TO CONTRIBUTING TO CA HOSPITAL: 1 Inpetiant 2 28e. DATE OF | (OR AS A CONSECTION OF AS A CONS | DUENCE OF DEAT | s I N (Check of the Control of the C | NO D | UNC | ERTAIN | PERFO 1 TYES | RMEO? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| PHYSICIAN: MEDICAL | If any, leading to immercuse. Enter UNDERLYI CAUSE (Disease or input that initiated events resulting in deeth) LAS PART II. Other eignifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 2 100 27. MANNER OF DEATH 1 Matural 5 | ont condition SE CONTR MEDICAL Pending | DUE TO DUE TO CONTRIBUTE TO CA HOSPITAL: Inpetiant 2 | (OR AS A CONSECTION OF AS A CONS | DUENCE OF DEAT | S IN (Check of Number 1) | NO Denly one) :: Ing Home 28c. INJI WO | UNC | ERTAIN sidence | PERFO 1 YES | RMEO? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLYI CAUSE (Disease or input that initiated events resulting in deeth) LAS PART II. Other eignification of the cause o | ont condition To SE CONTR D MEDICAL Pending investigation | DUE TO DUE TO CONTRIBUTE TO CA CIBUTE TO | (OR AS A CONSECTION OF AS A CONS | TH YE | S I I | NO Dinly one) i: ling Home 28c. INJI WOI 1 V | UNC 5 Re URY AT RK7 ES 2 | ERTAIN sidence | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 281. LOCATION (Street | INJURY OC | CUREO | AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLY! CAUSE (Disease or injut that initiated events resulting in deeth) LAS PART II. Other eignification of the cause o | ont condition SE CONTR MEDICAL Pending | DUE TO DUE TO CONTRIBUTE TO CA CIBUTE TO | (OR AS A CONSECTION OF AS A CONS | TH YE | S I I | NO Dinly one) i: ling Home 28c. INJI WOI 1 V | UNC 5 Re URY AT RK7 ES 2 | ERTAIN sidence | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW | INJURY OC | CUREO | AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLY CAUSE (Disease or Injuthat initiated events resulting in deeth) LAS PART II. Other eignifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 100 27. MANNER OF DEATH 1 Matural 5 1 2 Accident 3 Suicide 8 1 | ont condition SE CONTR MEDICAL Pending nestigation Could not be betarmined | DUE TO DUE TO CONTRIBUTE TO CA HOSPITAL: Inpetiant 2 28a. DATE OF (Month, D.) 28a. PLACE OF building, | (OR AS A CONSECTION OF THE CON | TH YE E OF DEAT DOA 28b. TIM | The un N (Check of Churry M Itreet, factor | NO Description of the service of the | UNC 5 Ra URY AT RK? ES 2 | ERTAIN sidence | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State | INJURY OC | CUREO | AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLY CAUSE (Disease or Injuthat initiated events resulting in deeth) LAS PART II. Other eignification of the cause of t | ont condition SE CONTR MEDICAL Pending Investigation Could not be letermined | DUE TO DUE TO CONTRIBUTE TO CA CONTRIBUTE TO | (OR AS A CONSECTION OF THE CON | TH YE E OF DEAT DOA 28b. TIM INJ The, farm, a | The unit of the un | NO Denity one) i: ing Home 28c. INJ pry, office | UNC 5 Ra URY AT RK7 YES 2 | ERTAIN sidence | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 281. LOCATION (Street City or Town, State to the cause(a) and ma | injury oc | CUREO r or Rural R | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLY! CAUSE (Disease or injut that initiated events resulting in deeth) LAS PART II. Other eignification of the cause o | T CONTROL OF THE PROPERTY OF T | DUE TO DUE TO CONTRIBUTE TO CA CONTRIBUTE TO | (OR AS A CONSECTION OF THE CON | TH YE E OF DEAT DOA 28b. TIM INJ The, farm, a | The unit of the un | NO Denity one) i: ing Home 28c. INJ pry, office | UNC 5 Ra FRA FRA FRA FRA FRA FRA FRA F | ERTAIN sidence in the sidence in th | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma | INJURY OC | CUREO or Rural R ted. | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLY CAUSE (Disease or Injuthat initiated events resulting in deeth) LAS PART II. Other eignification of the cause of t | T CONTROL OF THE PROPERTY OF T | DUE TO DUE TO CONTRIBUTE TO CA CONTRIBUTE TO | (OR AS A CONSECTION OF THE CON | TH YE E OF DEAT DOA 28b. TIM INJ The, farm, a | The unit of the un | NO Denity one) i: ing Home 28c. INJ pry, office | UNC 5 Ra FRA FRA FRA FRA FRA FRA FRA F | ERTAIN sidence | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma | INJURY OC | CUREO or Rural R ted. | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immedicates. Enter UNDERLY CAUSE (Disease or Injuthat initiated events resulting in deeth) LAS PART II. Other eignification of the initiated events resulting in deeth) LAS DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Anatural 5 1 CERT (Check only one) 2 MEDI 298. CERTIFIER (Check only one) 2 MEDI 298. SIGNA UP AND TITLE | ont condition To SE CONTR Depending meetigation Could not be determined IFYING PHYSIC CAL EXAMINER CERTIFIER | DUE TO DUE TO CONTRIBUTE TO CA HOSPITAL: 1 Inpetlant 2 28a. DATE OF (Month, D.) 28a. PLACE Of building, EIAN: To the best of at | (OR AS A CONSECTION OF AS A CONSECTION OF DEAT | TH YE E OF DEAT DOA 28b. TIMINJ THE, farm, a | S N (Check of the the the the the the the the the the | NO Denity one) i: ing Home 28c. INJ pry, office | UNC 5 Ra FRA FRA FRA FRA FRA FRA FRA F | ERTAIN sidence in the sidence in th | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma | INJURY OC | CUREO or Rural R ted. | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLY! CAUSE (Disease or injut that initiated events resulting in deeth) LAS PART II. Other eignification of the cause o | ont condition To SE CONTR Depending meetigation Could not be determined IFYING PHYSIC CAL EXAMINER CERTIFIER | DUE TO DUE TO CONTRIBUTE TO CA HOSPITAL: 1 Inpetlant 2 28a. DATE OF (Month, D.) 28a. PLACE Of building, EIAN: To the best of at | (OR AS A CONSECTION OF AS A CONSECTION OF DEAT | TH YE E OF DEAT DOA 28b. TIMINJ THE, farm, a | S N (Check of the the the the the the the the the the | NO Denity one) i: ing Home 28c. INJ pry, office | UNC 5 Ra FRA FRA FRA FRA FRA FRA FRA F | ERTAIN sidence in the sidence in th | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma | INJURY OC | CUREO r or Rural R ted. he cause(s) | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immedicates. Enter UNDERLY CAUSE (Disease or Injuthat initiated events resulting in deeth) LAS PART II. Other eignification of the initiated events resulting in deeth) LAS DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Anatural 5 1 CERT (Check only one) 2 MEDI 298. CERTIFIER (Check only one) 2 MEDI 298. SIGNA UP AND TITLE | T condition SE CONTR MEDICAL Pending Investigation Could not be letarmined IFYING PHYSIC CAL EXAMINER CENTIFIER | DUE TO DUE TO DUE TO CONTRIBUTE TO CA HOSPITAL: Inpetiant 2 28a. DATE OF (Month, D.) 28a. PLACE Of building, 28a. PLACE Of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of an open contribution of the beals of the | (OR AS A CONSECTION OF AS A CONS | DUENCE OF DESUITING FARM, a string of the occurrence of the occurr | S N (Check of the the the the the the the the the the | NO Denity one) i: ing Home 28c. INJ pry, office | UNC 5 Ra FRA FRA FRA FRA FRA FRA FRA F | ERTAIN sidence in the sidence in th | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma | INJURY OC | CUREO or Rural R ted. | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immer cause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in deeth) LAS PART II. Other eignifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Metural 5 1 2 Accident 3 Suicide 8 0 4 Nomicide 29a. CERTIFIER (Check only one) 2 MEDI 31. DATE FILED (Month, Dey, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (Month, DEY, 31. DATE FILED (MONTH, DEY, 31. DATE FILED (MONTH, DEY, 31. DATE FILED (MONTH, DEY, 31. DATE FILED (MONTH | T condition SE CONTR MEDICAL Pending Investigation Could not be letarmined IFYING PHYSIC CAL EXAMINER CENTIFIER | DUE TO DUE TO DUE TO CONPLETED CAUSE COMPLETED CAUSE COMPLETED CAUSE 32. DEGISTRA 32. DEGISTRA | (OR AS A CONSECTION OF AS A CONSECTION OF DEAT | DUENCE OF DESUITING FARM, a string of the occurrence of the occurr | S N (Check of the the the the the the the the the the | NO Denity one) i: ing Home 28c. INJ pry, office | UNC 5 Ra FRA FRA FRA FRA FRA FRA FRA F | ERTAIN sidence in the sidence in th | PERFO 1 YES 8 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma | INJURY OC | CUREO r or Rural R ted. he cause(s) | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |



BY FUNERAL DIRECTOR

BE COMPLETED

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

EXAMINER?

1 Natural 2 Accident

3 Suicide

4 Homicide 29e. CERTIFIER

27. MANNER OF DEATH

1 TES 2 NO

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | 96 | 03672 |
|--|--------------------|--------------------|---------------------|----------------|----------------------|-------------|------------------|-----------------------------------|------------|------------------|--|
| FOR STATE REGISTRAR | | STATE OF I | | | TMENT O | | | MENTAL HYGIE | | | 00072 |
| 1. DECEDENT'S NAME (First, | Miridle (set) | | | En ir | CATE | JE DE | AID | REG. N | O | | |
| Pina-K | le (| Chan | | | | | | | DAY 2.7 | YEAR 96 | 3. TIME OF DEATH 12:45 PM |
| 4. SOCIAL SECURITY NUMB | BER | 5. SEX | 6. AGE (In yrs. les | st birthday) | IF UNDER 1 YE | | DER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHP | PLACE (State or Foreign |
| 231-62-7534 | | 1 M 2 F | 94 | YRS. | | AYS HOURS | | (Month, Day, Year) SEPT. 2, 1 | 901 | MALA | |
| 90. FACILITY NAME (If not in | istitution, give s | itreet and number) | | | 9b. CITY, TO | WN OR LOCA | TION OF D | EATH | 9c. CO | UNTY OF DE | ATH |
| Potomac Val | Ley Nu | rsing Ho | me | | Rockville Montgomery | | | | | | ery |
| 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. I | | | | | | | | | | 10d. INSIDE CITY | |
| Maryland Montgomery Silver Spring | | | | | | | | LIMITS? 1 YES 2 NO | | | |
| 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT CO | | | | | | | | HAT COUNTRY? | | | |
| 1637 Nordic Hill Circle 20906 U.S.A. | | | | | | | | | | | |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No — 14. RACE — Ameri | | | | | | | | - American Indian, White, etc. | | | |
| 3 ☑ Widowed 4 ☐ Divorced IF YES, GIVE WAR OR DATES 1 ☐ YES 2 ※ NO Specify: Specify: | | | | | | | | | | | |
| Specify Chinese | | | | | | | | | | ese | |
| (Specify only | EDENT'S EDU | completed) | (G) | live kind of w | USUAL OCCU | | rking | 16b. KIND OF B | USINESS/IN | OUSTRY | |
| Elementary/Secondary (0-12) College (1-4 or 5+) life. Do NOT use retired.) | | | | | | | | | | | |
| 7 | | | Tra | nslat | cor | | | Malaysi | | | Court |
| 17. FATHER'S NAME (Flist, M. Kam Ming Ch | | | | | | | | AME (First, Middle, Maide | n Sumame) | | |
| 19e. INFORMANT'S NAME (T | | | 19 | MAILING | 120BERG /0 | | | ui Fung Route Number, City or R | 0 | | 20004 |
| Ken Chan | ypan maj | | | | | | | le Silve | | | 20906 |
| 20e. METHOD OF DISPOSITI | | | 20b. PLACE A | AND DATEO | OF DISPOSITIO | | OILC | | | - City or Tow | |
| 1 Buriel 2 Cremetlo 4 Donation 5 Other | | oval from State | cemetary, crei | ematory or oth | ther place) | | | | | | |
| 21. SIGNATURE OF EMBERAL | | CENSEE / | Inetto | DOTIL | tan Cr | ME AND ADDE | CY DESS OF FA | 1/31/96 A | Lexan | dria, | Virginia |
| 211 1 | 11 | 110 | 101 | | | | | lins Fune | ral H | ome. | Tnc. |
| Mark | 1. | 1/188 | een | | | | | y Blvd.,W | | | |
| 23. PART I. Enter the di shock, or hi | iseaeea, or c | complications the | at caused the de | ath. Do n | ot enter the | moda of c | lying, auc | h as cardiac or rea | piratory s | rreat, | Approximate interval Between |
| IMMEDIATE CAUSE (Fin | | and only one one | Tag our ower | | | | | | | | Onset and Daath |
| disease or condition resulting in desth) | → | - END | Stree 1 | I am I | Disar | | | | | | Yeup |
| leading in death, | | OUE TO | | | | | | | | | |
| | | · Diabet | (OR AS A CONSEC | + | | | | | | | Tens |
| Sequentielly list conditi If any, leading to immed | | OUE TO | (OR AS A CONSEC | JUENCE OF | ን: | | | | | | |
| cause. Enter UNDERLYi CAUSE (Disease or inju | | C | | | | | | | | | |
| thet initieted events | | DUE TO | (OR AS A CONSEC | DUENCE OF |): | | | | | | |
| resulting in deeth) LAS | | d | | | | | | | | | |
| DADT II Other sleetiles | =1 00=distan | | | - | | | | | | | |
| PART ii. Other algnifice | | f - | daeth but not re | ecuiting in | n the under | tying ceuse | given in | Part i. 24e. WAS A | N AUTOPSY | | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| Cozentia | heni | dulum | | | | | | 1 □ YES | 2 N/NO | | COMPLETION OF CAUSE |

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗆 NO 🔯 25. WAS CASE REFERRED TO MEDICAL

1 | Inpatient 2 | ER/Outpatient 3 | DOA

UNCERTAIN 26. PLACE OF DEATH (Check only one)

OTHER: Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. OESCRIBE HOW INJURY OCCURED

28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?

1 YES 2 NO 28b. TIME OF INJURY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 _ CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner as atlated.

| one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in m | ry opinion, death occured at the time, date end place | , and due to the ceuse(s) end manner as stated. |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d DATE SIGNED (Month One Vent) |

14.9 WHO COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print)

Investigation

8 Could not be determined

HOSPITAL:

Congressional Lane Rockville, Maryland 20852-1598

29c. LICENSE NUMBER

D01197

Sidney 31. DATE FILED (Month, Day, Year) 1996 1 | YES 2 | NO

29d. DATE SIGNED (Month, Day, Year) 11-27-96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03673

| | | | | | | | Cert | ificate o | f Death | 7 | | Reg. No. | | 00010 |
|--|--|------------------|---|------------------|-------------------------------|--------------------------------|-------------------------|--|------------------------|------------|----------------------|------------------|---------------|--|
| | | | 1. Decedent's Name (First, Middle | , Last) | | | | | | | 2. Dete of De | eth | W | 3. Time of Deeth |
| | Physici | | | Cowa1 | 1 | | | Jan. | | | | | | |
| | /Medi Examir | | 4a. Facility Name (If not institution | , give street an | d number) | | | | 4b. City, To | own, or Lo | ocation of Deat | | y of Deeth | ,,,,,, |
| 1 | Exami | | Suburban Hosp | ital | | | | | Beti | hesda | a | Mo | ntgom | erv |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age | (In yrs. last bir | | If Under 1 Ye | ar If Under | r 24 Hrs. | 9 Date of Bir | th | 9. Birth | piece (Stete or Foreign |
| | Director | | 578-50-4361. Usual Residence of Decedent | 1 ™ M 2□ | 8. | 5 | Yrs. | Months Day | /s Hours | Min. | (Month, Di Apr. 2 | 2, 1910 | Cou | Iand |
| and | ž.,, | | 10a. Stete 10b. County 10c. City, Town or Location | | | | | | | | | | Т. | 10d. Inside City Limits |
| Aary | of a | 5 | MD Mont | | | | | | 01 | | | | | 1 Yes 2 No |
| tha | 280 | Funeral Director | 10e. Street and Number | gomery | | | | 10f. Zip Code | evy Ch | lase | | 10g. Citizen of | Minat Cour | -ta-0 |
| ¥. | DEBILITIONE, MISTYIANG Z1Z13-UUZU permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Exercises must be notified as once. | | 8100 Connecti | out Arro | D110 | | | Toil. Zip Cour | | 2081. | 5 | | S. A. | |
| ath | | | | | Decedent Ev | ver in LLC | 10.18/ | 3. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) | | | | | ce - Ameri | |
| e. | | | 11. Maritei Stetus 1 ☐ Never Merried 2 ☑ Marri | Arme | ed Forces? | | IS. W | es, specify C | uban, Mexice | n, Puerto | Rican, etc.) | Ble | ck, White, | |
| Z1Z15-0020 d within 72 hours af | P. O. | by F | 3 ☐ Widowed 4 ☐ Divorced | If Ye | s, Give or Detes: | , | 1 ☐ Yes 2 ☑ No Specify: | | | | | Speci | y: Wh | ite |
| 2 2 2 | E | Completed | 15. Decedent | s Education | A. iB | 16a. | . Decede | nt's Usuel Occ | cupation | | 1. | 16b. Kind of 8 | Businass/In | dustry |
| 21.2 Pin 7 | - 5 | ple | (Specify only highes Elementery/Secondary (0-12) | 1 | eted) ege (1-4or 5+ |) | life. DC | nd of work doi NOT use ret | ne during mo: ired) | ing | | | | |
| 21 M | Ser a | PO. | | | 5 + | ' | Cler | gyman | | | | Relig | ion | |
| Maryland | A de la | Be (| 17. Fether'e Neme (First, Middle, I | | | | | | 18. Moth | er's Nam | e (First, Middle | , Meiden Suma | me) | |
| <u>a</u> | Aentred tic e | To | James Lindsay | Cowall | | | | | Jes | se A | dair | | | |
| e ods | Du a | | 19e. Informant's Neme/Relationsh | nip (Type, Print |) | 196 | . Mailing | Address (Stre | et and Numb | er or Run | al Route Numb | er, City or Town | n, State, Zip | Code) |
| M Spue | 27 l | | Madeleine L. | Cowall | | 81 | 00 C | onn. A | ve. C | hevy | Chase, | MD 20 | 815 | |
| ore s | of He | | 20a. Method of Disposition | | | cemete | rv. crema | tion (Neme of | olece) | | Date | 20c. Location | - City or To | own, State |
| E gad | ury o | | 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetiop 5 ☐ Other (Sp | | rom Stete | Fort I | Linco | ln Cem | netery | 1 | /29/96 | Brentwo | ood, | MD |
| altimore, | Departn Imports any Inju | | 21. Signature of Funerel Service I | icansee | V. | 1 | 22.1 | Name end Ade | dress of Fecil | ity Jos | eph Gay | vler's | Sons | |
| n Š | 8 5 5 8 | | 1 hernon |) \ | Rous | nors | | | | | | nington | | . 20016 |
| | - | | 23a. Pert1. Enter the disease, or shock, or heart failure. List | complications t | hat caused t | he deeth. Do | not enter | the mode of o | tying, such as | s cardiec | or respiratory a | rrest, | | Approximate Interval Between |
| Ph | Physician | | 3.1001, 3.11001, 1811010, 2001 | only one sauce | 011 00011 11110 | | | | | | | | | Onset and Death |
| | Medical | h., | Immediate Cause (Final disease or condition | | 14 | | | | | | | | 1 | 1 hour |
| E | kaminer | 1 | resulting in deeth) | eC | | ulmona: Due to (or as a | | | | | | | | 1 Hour |
| D | 25 | iner. | | | oronar | y insu | ffic | iency | | | | | 1 | 8 years |
| cute | nd trans | Examiner | Sequentially list conditions, | | | ue to (or es a | | | | | | | | 0 10010 |
| Č Š | urial- | 0 | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | 1 | | |
| 5875U, | hysic the b | edical | thet initiated events resulting in deeth) Lest | C | D | ue to (or as a | conseque | ence of): | | | | | | |
| entific o | a as | | | 4 | | | | | | | | | | |
| ords, F.O. BOX 68/60, requires that the death certificate be assocuted | attending physician and for usa as the burial-transit | Physician/ | | | | | | | | | | | 1 | |
| . § | the de | ysk | Part II. Other eignificant condition | ns contributing | to death but | not resulting is | n the und | erlying cause | given in Pert | l. | 23b. Dld | tobacco uee c | ontribute t | o the cause of death! |
| . å | ed by the atter | | Osteoarthrit | is | | | | | | | 10 | Yee 2 No | 3 Pro | bably 4 Unknow |
| VICAL RECORDS, P.O. | signed b | d b | | | - | | | | | | 24a Was | an eutopsy | 24h W | ere autopsy findings |
| | peen si | Completed | Prostatic Hy | perpla | sia | | | | | | | ormed? | 81 | vailable prior to empletion of cause |
| ie C | N 56 | 1du | | | | | | | | | | | of | deeth? |
| E P | pag. | ဒ | | | | | | | | | 10 | Yes 20 No | 1 | □Yes 2□No |
| | certificate rector, par | Be | 25. Was case referred to medical examiner? | 14 - 2-1 | | | | | | e of Deet | h (Check only | one) | | |
| O E | this o | 2 | 1 ☐ Yes 2 ☑ No | | 1 Inpatien | | • | 30 000 | | | | idence 6 🗆 O | | fy) |
| VISION OF VITA Attending Physician: | ar death. ector: After this certificate he by the funaral director, paga | inol | 27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending | . (| Date of Injury (Month, Day | | Time of Injury | 28c. lr | | | 28d. Describe | how injury occu | irred | |
| Sign Sign Sign Sign Sign Sign Sign Sign | daath. | cat | 2 Accident investig 3 Suicide 6 Could n | ot be | | | | | Yes 2 | | | | | 10.00 |
| or Attending Phys | after death. Director: After I in by the funa | Certification: | 4 ☐ Homicide determi | ned 200. t | puilding, etc. | y - At home, fa (Specify) | ırm, stree | it, fectory, offic | 00 | | City or To | wn, State) | iber or Hur | al Route Number, |
| J is | Pra line | 1 - 1 | 29a. Certifier 1₩ Certifying | Division T | - 4h - 1 4 - 4 | and the section desired | | | Af | | | | | totad |
| Hos | within 24 hours aftar d To the Funeral Direct completely filled in by | edical | | xaminer: On t | | examination en | | | | | | date and place | | |
| the | ithin o the | M M | 29b. Signature and title Contiller | - Cilio | marinor otot | | | 29c. Lioc | nse number | | | 29d. Date sign | ed (Month, | Day, Year) |
| F | 3 F 0 | | 1 Laure | XX | 900 | 00.5 | | - | | | | Januar | | and the state of t |
| | | | 20 1 | 0/0 | pu | 1000 | re. = | | 4686 | | | SOME STATE OF | | |
| | | | 30. Name and address of person v | | cause of dec | eth (Item 23e) 520 - 1.12 - | (Type, Pr | odn "Su | ite 54 | 0. 0 | hace h | 1D 208 | 15_/./. | 26 |
| | - 0 | | Robert F. Dyer 31. Date filed (Month, Dey, Year) | | | | | | . cne | vy C | nase, I | w 200. | J-441 | 00 |
| | Sta Registr | _ | JAN 30 | 1996 | July at | 's Signature | ardall | | | | | | | |

| | | | | | | | C | ertific | ate of | Death | | | Reg. No. | | | |
|------------|--|----------------|---|------------------|--------------------------|---------------------------|------------------|------------------------|--------------------------|------------------|--------------|------------------------------|--------------------------------------|-----------------|--|--|
| П | | | 1. Decedent's Nema (First, Mid | die, Last) | | | | | | | Ī | 2. Data of De | | W | 3. Time of Death | |
| | Physic | | Alice Bouldin | Cox | | | | | | | | Month Januar | y 25, | Year 1996 | 9:40pm | |
| | /Medi Exami | | 4a. Facility Neme (If not institut | ion, giva st | reet and nu | m <i>bar)</i> | | | | 4b. City, To | | cation of Deat | | nty of Deeth | | |
| 1 | m.Autti | | Fox Chase Nur | inc: | Home | | | | | Si 1376 | er Sp | rino | Mont | gomer | -37 | |
| | Funeral | | 5. Sociel Security Number | 6. Sax | TOME | 7. Aga (in y | rs. last birthda | | dar 1 Yeer | If Unda | | 8. Dete of Bir (Month, De | | ~ | pleca (Stata or Foreign intry) | |
| Į. | Director | | 578-20-3721 | 1 🗆 | M 2⊠F | (| 90 Yrs. | Mont | hs Days | Hours | | | a <i>y, Year)</i> 0 , 1905 | Cou | intry) ginia | |
| | | | Usuai Residanca of Dacedant | | | | , , | | | | | reb. Z | 0, 190. |) VII | griita | |
| | yland | | 10a. State 10b. Cour | ty | | 10c. | City, Town or | Location | | | | | | | 10d. Insida City Limits | |
| | Me I | to | Maryland Mont | gomer | ·v | | Germant | :own | | | | | | | 1 ☐ Yas 2 ₺ No | |
| | 284 | Director | 10e. Street end Number | | | | | | Zip Coda | | | | 10g. Citizan of Whet Country? | | | |
| | With With | 0 | 120/0 Vanaham | Harra | Llass | | | 20 |)874 | | | | II and the a | 1 (4-4 | | |
| | Seath 22 | Funerai | 12848 Kitchen | | - | edent Ever In | U.S. 13 | | | lispenic Or | igin? (Spe | cify Yas or No | United | Race - Amari | | |
| | Her of Her of | Fun | Armed Forcas? If Yes, s 1 □ Navar Married 2 □ Merried 1 □ Yas 2 ⅔ No | | | | | pecify Cub | en, Maxice | n, Puarto F | Rican, etc.) | | Black, Whita, | | | |
| 20 | Ir. or | by | 3 ☐ Widowad 4 ☑ Divorce | | If Yas, Gir Yaar or D | va | | 1 🗆 Ya | 2 2 No | Specify | : | | Spe | | hite | |
| 21215-0020 | within 72 hours effer death with the Meryland isne. Than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at | P | 15. Deced | ent's Educa | ation | | 16a. Dec | cedant's L | Isual Occup | ation | | | 18b. Kind of | Businass/In | | |
| 7 | nin 7 | Completed | (Specify only high | | | | (Girla | va kind of L. DO NO | work dona Tusa ratire | during mos d) | st of workir | ng | | | , | |
| 212 | | mo. | Eiamantary/Secondery (0-12 | , | Collega (| 1-40f 5+) | Cle | rk | | | | | Federa | al Gov | vernment | |
| D | al Hygie other vent, ti | | 17. Fathar's Nama (First, Middl | e, Last) | | | 010. | | | 18. Moth | ar's Nama | (First, Middle | , Meldan Sum | | | |
| ar | d be enta | To Be | Claiborne Bou | ldin | | | | | | Mars | Cru | mn | | | | |
| 2 | M M | - | 19e, Informant's Name/Raiatio | | e. Print) | | 19b. Me | aillna Addr | ess (Streat | | | _ | er, City or Tox | vn Stata Zi | in Code) | |
| Maryland | permit. Peges 1 end 2 should be liled Department of Heelth and Mental Hyg Important: If Item 27 Is marked other Important: If Item 27 Is marked other any injury or other traumatic event, | | James T. Cox | (So | | | | | | | | | nantown | | | |
| é | Hee Hee | | 20a. Mathod of Disposition | (30) | 11) | 208 | . Place of Dis | position (| Nema of | | e way | Data Data | | n - City or T | | |
| no | nt of nt of the second | | 1 ☐ Burial 2 X Cramation | | moval from | Stata | cematary, c | ramatory | or othar pla | | | | | | | |
| Baltimore, | rtant Juny | | 4 Donation 5 Other | - | | M | etropo. | | | | | | | | ı, Virginia | |
| Ba | Depa Impo any i | | 21. Sonature of Funarel Sarvio | e Licanse | | 00 | | | end Addre | | | | uneral | Home | | |
| | TD = 0 0 | | Meho | ~ | W | ulik | aus | Gait | last I hersb | burg, | MD 2 | 0877 0877 | | | | |
| П | | | 23a. Part1. Enter the disease, shock, or heart failure. Li | or complica | ations that o | ausad tha da ach lina. | aath. Do not e | entar the r | noda of dyir | ng, such as | cerdiac o | r raspiratory a | rrest, | | Approximata Intarvei Batween | |
| 1 | Physician | | | | | | | | | | | | | | Onsat and Deeth | |
| h. | /Medical | | Immediete Causa (Final disaase or condition | | Card | iopulm | onary A | Arres | st | | | | | | Minutes | |
| 10 | Examiner | | rasulting in daath) | a. | | _ | (or es e cons | | | | | | · | | | |
| | ס א≡ | ine. | | | Uros | ensis | | | | | | | | | Days | |
| | nd | Examiner | Sequentially list conditions, if any, laading to Immadiata | В. | 0200 | | o (or es e cons | sequance | of): | | | | | | | |
| 68760, | ertificate be executed Jing physician end se es the buriel-transit | | cause. Entar Undarlying | J | Pneu | monia | | | | | | | | i | Days | |
| 376 | ate b nysic he b | edicai | Ceusa (Disaasa or Injury thet Initiated avants resulting In daath) Lest | C | 111001 | | (or as a cons | equance | of): | | | | | | 200,0 | |
| 9 | death certifica ettending ph d for use es t | Med | rooting in duality Lost | L. | Domos | atia | | | | | | | | 1 | | |
| XOX | 0 2 2 | an | | d | Deme | пста | | | | | | | | 1 | | |
| œ. | death se etter ed for u | Physician | Part II. Other significant condi- | tlona contr | ibuting to de | eath but not r | resulting In the | undarlyir | g ceusa giv | an in Part | l, | 23b. Dld | tobacco uae | contribute 1 | to the causa of death? | |
| <u>Р</u> | thet the de ed by the e | hy | | | | | | | | | | 10 | Yes 2□N | a 3□ Pro | bably 4™Unknow | |
| ŝ | es the | by | | | | | | | | | | | | | | |
| Ď | E O D | | | | | | | | | | | | en eutopsy ormed? | | Vera autopsy findings velleble prior to | |
| ecord | _ 0 | piet | | | | | | _ | | | | pari | omegr | CC | ompiation of cause f deeth? | |
| α | The law ate has page 2 | Completed | | | | | | | | | | 10 | Yas 2 No | | □Yas 2□No | |
| Vital | | 0 | 25. Was cese raferrad to medic | al | | | | | | 26 Blac | o of Dooth | (Check only | | | | |
| > | | OB | axaminar? 1 ☐ Yes 23 No | | spitel: | Inpatiant 2 | ☐ ER/Outpati | lant 20 | DOA Oth | or: | | | Idance 6 🗆 (| Other (Cons | 26 a) | |
| o | | | 27. Mannar of Deeth | | 28a. Data | | 28b. Tima | _ | | | | | how injury oc | | iy) | |
| On | After fune | tior | 1 Natural 5 Pend | ling tigation | | th, Day Year, | | | 28c. Injur Wor | k? Yas 2□ | | | | | | |
| S | Attending r death. sctor: Afte by the fune | fica | 3 ☐ Suicida 6 ☐ Coui | d not be | 28a Piace | of injury - At | t home, farm, | straat fac | | | | 8f. Location (| Straat and Nu | mber or Rui | ral Route Number, | |
| Division | or Attendent efter deat Director: | Certification: | 4 Homicide | mined | | ng, atc. (Spe | | oridat, ido | tory, orrida | | | | wn, Stata) | | | |
| _ | To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the | | 29a. Certifier 1 X Certify | ing Dhyels | Jan. To the | hant of my le | moudodes de | ath assum | ad at the time | no dete de | ed alega a | and alive to the | | | atatad | |
| | Hos Fun Fun | edicai | | I Examine | On the ba | asis of axami | ination and/or | investigat | ion, In my o | pinion, dec | oth occurre | d et the tima, | ceuse(s) end deta end pled | e, and dua t | to tha causa(s) | |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifi | ior | Landa | | | | 29c. Licans | a number | | | 29d. Data sig | nad (Month | Day Year) | |
| | F ₹ F 8 | | 1/ | 1 | H | / | | | and Liverin | | | | Lou. Data org | riad (irrollar) | 20, 100, | |
| | | | - O Gu | -04 | NI | ~~ | | | _D 44 | 120_ | | | Janua | cy 27, | 1996 | |
| | | | 30. Name and eddress of parso | | | | | | | | – | | | | | |
| | | | Takao L. Sato | | | | | Pike | Suit | e #3 | 16, R | ockvil | le, MD | 20852 |) | |
| | Sta | | 31. Data filed (Month, Dey, Yea | 7) _ | 32. R | agistrar's Sig | natura 🕜 | | | | | | | | | |
| | Registr | | FEB | UI 19 | 46 1 | who die | video Re | rdall | | | | | | | | |
| DH | MH 16 Rev 6/9 | 5 | | • | U | | | | | | | | | | | |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 03675 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Day 28 1996 Crutchfield 05:15 pm Marjorie January /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2KXF Months Deys Y_{re} Director 215-36-7438 87 June 2, 1908 Maryland Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan and Health and Mental Hygiene.
Int if item 27 is marked other than "natural", or items 23a or 28a-f ahov in or other traumatic event, the Modical Examples mounted. 1 XYes 2 No Directo Maryland Montgomery Takoma Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7620 Maple Avenue, Apartment 110 Funerai 20912 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Detes: 1 ☐ Yes 2 XNo ģ Specity: 3 X Widowed 4 ☐ Divorcad Black Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be 2 Robert Taylor Gertrude Stewart 19e. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rev. William S. Crutchfield/Son 9116 September Lane, Silver Spring, Maryland 20901 20b. Piece of Disposition (Neme of cametery, cremetory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Department of Important: If H any Injury or o 1 N Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2-1-96 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service L 22. Name and Address of Fecility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Physician/Medical Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probabiy 4 | Unknown by 24e. Wes en eutopsy periormed? 24b. Were eutopsy findings Completed evelleble prior to completion of cause of deeth? 20 No 1 Tyes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpetient DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturei 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 8 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted. 29b. Signature and tit OXONHILL RJ 8219 30. Neme and addition of person who completed cause of deeth (Item 23a) (Typa, Print) SUIT

D. OXON HILL

State Registrar

FEB

SAEE

KOOLAEE. Strar's Signature

Mudion Ravial 31. Dete filed (Month, Dey, Yeer) 01

DHMH 16 Rev 6/95

the Maryland

Baltimore, Maryland 21215-0020

Box 68760,

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Division of Vital Records, P.

The law requires that the death certificate be

Hospital or Attending Physician:

the

death.

ŝ signed by the

peed

certificate

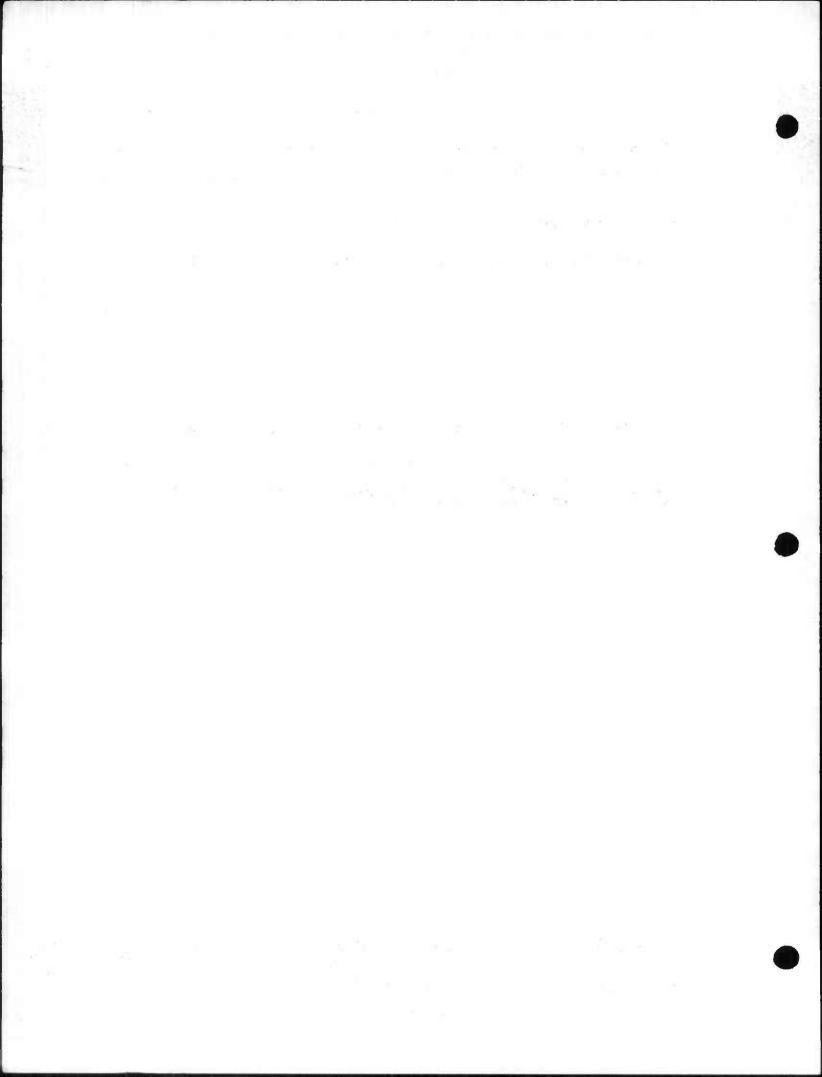
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After

after death Director: / d in by the f

within 24 hours aft To the Funeral Di completely filled in

28a-f ahow



| | _ |
|---------------------------------------|--|
| 020 | physician |
| BALTIMORE, MARYLAND 21215-0020 | etained by the hospital or attending physicial |
| 7 | 9 |
| ND | hospital |
| A | the |
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| 2.1 | 2 |
| 8 | ge 6 may be ret |
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| Z | eath. Page |
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| 9 | within |
| X 6876 | e executed within 24 hours after |
| × | 0 |

DIVISION OF VITAL RECORDS, P.O. BO

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|
| IG PHYSICIA | ler this certi | narked, or |
| R ATTENDIN | IRECTOR: Aff | sm 28 is n |
| HOSPITAL OF | UNERAL DI | ANT: If Ite |
| TO THE | TO THE | IMPOR |

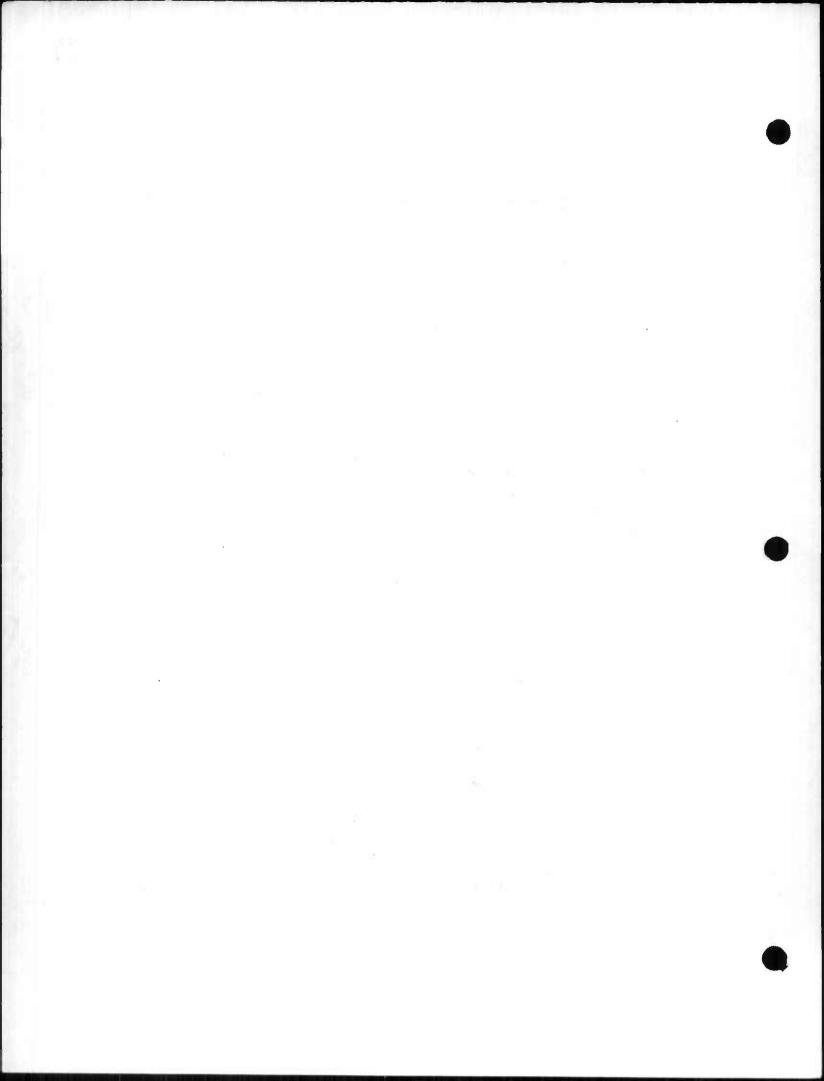
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|--|---|---------------------------------------|----------------------|------------------------|---|--------------------------|--|---------------------|----------------|--------------------------------------|--|
| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | O / DEPART | | | | WENTAL | HYGIENE REG. NO. | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE C | | YE | 3. TI | ME OF DEATH |
| | LAUREN (4. SOCIAL SECURITY NUMBER | | | | | | | 30 | 1996 | | 9-P" |
| | 216-60-4712 | 1 M 2 M = 4 | - | IF UNDER 1 | DAYS | HOURS MIN. | | Day, Year) -04-5 | Z | Spriny) akoma | Park, MD |
| OR | HOWARD COUNTY (| SENERAL HOS | PITAL | 9b. CITY | DL DL | Um BI | | | 9c. COUNTY | OF DEATH | 40 |
| DIRECTOR | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | 10c. CITY | TOWN OF | R LOCATIO | ON | | | 10d. | INSIDE CITY | |
| DIR | Maryland Howar | :d | Rocky Gorge | | | | | | | | YES 2 X NO |
| AL | 10e. STREET AND NUMBER | | | | 10f. | ZIP CODE | | | 10g. CITIZEN | | COUNTRY? |
| FUNERAL | 10350 Derby Drive | | | | | 2072 | | | | USA | |
| BY FUI | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | ARMED NO | 86 | yes, spe | ENDENT OF HISPAN city Cubari, Mexica 2 X NO Specify | n, Puerto Ri | | | Black, Whi | merican Indian, te, etc. White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, bo. NOT use retired.) 16e. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | Educat | | | |
| MP | 17. FATHER'S NAME (First, Middle, Lest) | 4+ | Schoo! | Tea | che | | | | | | |
| | John M. Ferro | | | | | Marguer | | | | | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS | (Street en | nd Number or Rural I | | | | do) | |
| 5 | Francis Carmody | | 10350 | Derb | y D | rive, Ro | cky (| Gorge, | MD 2 | 0723 | |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remote 4 Donation 5 Other (Specify) | vel from State 20b. PLA | CEAND DATEO | FDISPOSI ner piece) | TION (Nan | neof | 2/3/9 | 20c. LOC | ver Si | or Town, S | tete MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | 22. P | AME AN | D ADDRESS OF FA | CILITY | | | | |
| | Francis J. Collins Funeral H 500 University Blvd.W. Sil.S | | | | | | | | | | |
| | 23. PART I: Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List dniy one cause on each line. Approximate interval Between Onset and Death | | | | | | | | | | |
| | disease or condition resulting in desth) | Haute M. | accerdial Infarction | | | | | ~ | | | hoves- |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Car day |
| ON | Sequentially list conditions, | SUBTO (OR AS A CO | NSEQUENCE OF |): | | | | | | | gears |
| AT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| RTIFICATION | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A CO | NSEQUENCE OF |): | | | | | | | |
| | resulting in death) LAST | | | | | | | | | | |
| L CE | PART ii. Other significant conditions | contributing to death but r | not resulting l | n the un | deriying | ceuse given in | Part i. | 24a. WAS AN | | | E AUTOPSY FINDINGS |
| MEDICAL | hyper typroid | ism | | | | | | PERFORM | | COM | LABLE PRIOR TO PLETION DF CAUSE JEATH? |
| MEC | 0, 0 | | | | | | | | | | YES 2 2 NO |
| | DID TOBACCO USE CONTR | IBUTE TO CAUSE OF D | EATH YE | S 🗆 N | 10 🖪 | UNCERTAIL | N | | | | |
| PHYSICIAN: | 25. WAS CASE DEFERRED TO MEDICAL EXAMINER? | HOSPITAL: | PLACE OF DEAT | OTHER | - | | | | | | |
| YSI | 1 TES 2 NO | 1 Inpatient 2 (1) EN/Outpatie | | 4 🗆 Nurs | ing Home | 5 Reeldence | | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIMI | | 28c. INJU | PRY AT RK? ES 2 NO | 28d. DEŞ | CRIBE HOW IN | JURY OCCUR | ED | |
| ВУ | 2 Accident investigation | 28s. PLACE OF INJURY — | At home, farm, s | tractrincto | | | 281. LOCATION (Street and Number or <u>Rural</u> Route Number, | | | | Number, |
| OMPLETED | 4 Homicide determined | Could not be building, etc. (Specify) | | | | | | | | | |
| J.E | 290. CERTIFIER 1 CERTIFYING PHYSIC | JAN: To the best of my knowledg | e, death occurre | d at the ti | me, date | end piece, end due | to the cau | se(e) end meni | ner as stated. | | |
| MC | (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, end dus to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(e) end menner es stated. | | | | | | | | | | |
| EC | 296. SIGNATURE AND TITLE OF CERTIFIER | | tout | M | | 29c. LICENSE NUI | MBER | | 29d. DATE SI | | |
| 0 | Laty ce A E | my " | D314 | 13 | | DZIY | 73 | | 10 | -3 | ०,११९७ |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type | Print) | | | | | | | 210:10 |

29d. DATE SIGNED (Month, Day, Year) 30,1996 21042

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A-TOTE

TE 4565 HEM WILL CONE WMY THISTICITY MO MIN DRUGGETHARS SIGNATURE

DATING B-



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| tained by | should b | fiffied 2 |
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| аде 6 т | director, | adical examiner must be |
| death. P | funeral | vamin |
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| d within | completely nal, cremar | natic event the madi |
| execute | to burial, cr | matic |
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| es that | gned by | Ve 2nv |
| w requir | been si | 2 chow |
| The la | tate Der | fam 2 |
| YSICIAN | ter this certificate has been significant with the State Deot, of He | and as item 23 shows any injury or other traumati |
| G P | ter thi | marke |

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: TO THE FUNERAL DRECTOR: After this certificate be filed within 72 hours after death with the Stat IMPORTANT: If Item 28 is marked, or Ite

Obened by Dr. Mayle Medical Examiner on January 28, 1996

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

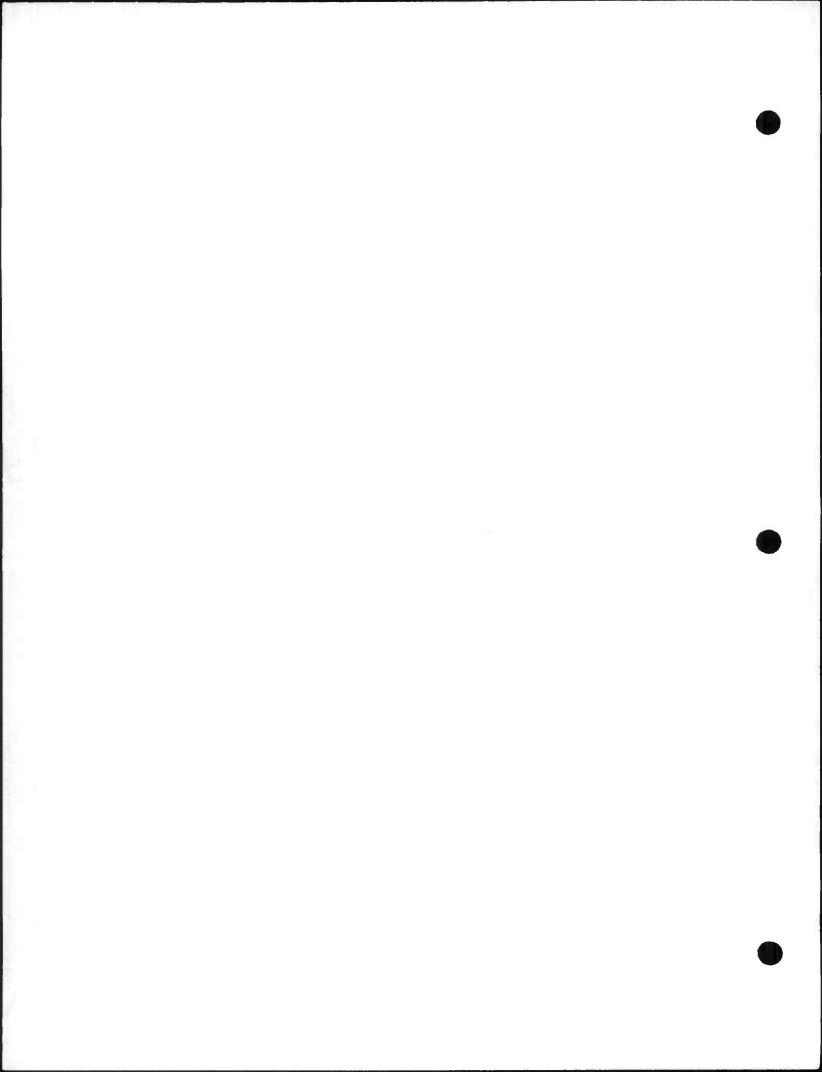
| 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO. | | | | | | | | | | |
|---|--|--|---------------------|-------------------------|--|-------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last | | | | 2. DATE OF DEATH | 2. DATE OF DEATH 3. TIME OF D | | | | | |
| Щ | orace | <. | Caldwe | 211 | January 2 | å, 199 | 6 4:30 A M | | | |
| 4. SOCIAL SECURITY NUMBER | | MO | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | D. BIRTNPLACE (State or Foreign Country) | | | |
| 164-07-4115 9a. FACILITY NAME (If not institution, give | 1 M 2 F | 84 YRS. | | R LOCATION OF DI | | , , , , , , , , , | | | | |
| Manor Care Bethe | | | Chevy (| | | Montgomery | | | | |
| 10a. STATE 10b. COUN | ТҮ | 10c. CITY, T | OWN OR LOCAT | ION | | | 10d. INSIDE CITY | | | |
| 10e. STREET AND NUMBER | | Was | shingto | on, DC | | B3730 - 17-17-17 | LIMITS? 1 X YES 2 NO EN OF WHAT COUNTRY? | | | |
| 1400 Montague St | reet NW | | 101 | 20011 | | - | ted States | | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS DEC | L 0011 | VIC ORIGIN? (Specify Ye | | 4. RACE — American Indian. | | | |
| 1 Never Married 2 Married 3 Wildowed 4 Divorced | 3 2 NO DATES | | ecify Cuban, Maxica | in, Puerto Ricen, etc.) | | Specify: White | | | | |
| 15. DECEDENT'S ED (Specify only highest grad | | 16e. DECEDENT'S US (Give kind of work | done during mo | N st of working | 16b. KIND OF BU | SINESS/INDUS | STRY | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Assistant Director | etired.) | | Univers | ity of | Maryland | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | Intrector | or rers | | ME (First, Middle, Meiden | | Maryrand | | | |
| | dwell | | | Maria | | | | | | |
| 190 INFORMANT'S NAME (Type/Print) Larry L. Chatma | in | 196. MAJLINO AD Same | | nd Number or Rural | Route Number, City or Tox | n, State, Zip C | (ode) | | | |
| 20s. METHOD OF DISPOSITION 1 Burlel 2 Commetter 3 Re | 20 | Ob. PLACE AND DATE OF D | | me of | | | ity or Town, Stata | | | |
| 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | Chesapeak | | STORY | | tsvill | e, Maryland | | | |
| · Eleen | W. Ra | RO | Rapp | Funeral | Services, nue, Silve | | | | | |
| 23. PART I. Enter the disesses, or shock, or heart failure | complications that cause. List only one couse on | ed the death. Do not | | | | | | | | |
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) | | | À | | | | Chronic | | | |
| Testing in death) | DUE TO (OR AS | A CONSEQUENCE OFF | + N: | Oaco. | | | chronia | | | |
| Sequentially list conditions, if any, leading to immediate | | A CONSEQUENCE OF): | -J DIS | caje | | | ch ron 16 | | | |
| cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c. DUE TO (OR AS | A CONSEQUENCE OF): | | _ | | | | | | |
| resulting in death) LAST | d | | | | | | | | | |
| PART II. Other eignificant condition | one contributing to deeth | but not resulting in t | the underlying | g ceuee given in | Part I. 24a. WAS AP | | 24b. WERE AUTOPSY FINDINGS | | | |
| Prostate | | | | | PERFO | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? | | | |
| | | | | | | | 1 TYES 2XX NO | | | |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL | TRIBUTE TO CAUSE | OF DEATH YES | | UNCERTAI | NUL | | | | | |
| EXAMINER? | HOSPITAL: | _ 0 | THER: | P Desidence | | | | | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year | 26b. TIME O | F 26c. INJ | | 6 Other (Specify) 26d. DESCRIBE NOW | INJURY OCCU | IRED | | | |
| 1 X Netural 5 Pending 2 Accident Investigation | | 270 | M 1 🗆 ' | rES 2 NO | | | | | | |
| 3 Suicide 6 Could not b | 28a. PLACE OF INJUI building, etc. (Sp | RY — At home, ferm, stre | et, factory, offic | • | 26f. LOCATION (Street City or Town, State | end Number o | r Rural Route Number, | | | |
| 1 | SICIAN: To the best of my kno | | | | | | | | | |
| | | ion and/or investigation, i | in my opinion, d | esth occured at the | time, data and place, a | nd due to the | cause(a) and manner ea stated. | | | |
| SIGNATURE AND TITLE OF CERTIFIC | LAMY MD | | | 29c. LICENSE NU | | | SIGNED (Month, Day, Year) Jary 29, 1996 | | | |
| 30. NAME AND ADDRESS OF PERSON V | | | · . | | | | | | | |
| Alvin Madarang, | | O Wisconsi | n Aven | Je, #124 | 8, Chevy | Chase, | , MD 20815 | | | |
| 31. DATE FILED (Month, Day, Year) JAN 3 0 1996 | 32 REGISTRAR'S SIG | anature on Royle II | | | | | | | | |
| JAN 9 () 133(| Jane war | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIF | CATE | OF DEATH | REG. NO |). | | | | |
|---------------|--|---------------------------------|----------------------------|----------------|---|---|--------------------|--|--|--|--|
| 1 8 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF OEATH | | | |
| | Louise M. Corey | | | | | January | 25. 199 | 6 5:00A M | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | GE (In yrs. last birthday) | IF UNDER 1 YE | EAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | RTHPLACE (State or Foreign | | | |
| | 032-03-7320 | 1 M 2 TF | 79 YRS. | MONTHS DV | AYS HOURS MIN. | (Month, Day, Year) Aug. 2, 1 | Co | ssachusetts | | | |
| | 9a. FACILITY NAME (If not institution, give | street end number) | | 9h CITY TO | WN OR LOCATION OF DI | | 9c. COUNTY C | | | | |
| 20 | | | | | | EATH | | | | | |
| 18 | 3387 South Leisu | re world Bo | ulevard | SILVE | er Spring | | Montgo | mery | | | |
| DIRECTOR | 10a STATE 10a COURTY | | | | | | | | | | |
| 1 8 | Maryland Mont | gomery | | Silv | er Spring | | | 10d, INSIDE CITY LIMITS? 1 TYES 2 X NO | | | |
| | 10e. STREET AND NUMBER | 9-110-7 | | | 101. ZIP CODE | | 10g. CITIZEN OF | | | | |
| 8 | 3387 S. Leisure W | orld Blvd. | | | 20906 | | | States | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | ED IN II C ADMED | I so uno | | | | | | | |
| | 1 Never Married 2 Married | FORCES? 1 Y | ES 2 NO | If yo | OECENDENT OF HISPAN 8, specify Cuben, Mexico | n, Puerto Ricen, etc.) | e or No — 14. H | IACE — American Indian, Ilack, White, etc. | | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR O | R DATES | 10 | YES 2 XNO Specifi | у: | S | White | | | |
| 0. | 15. DECEDENT'S EDU | JCATION | 16a. DECEDENT'S | ISHAL OCCU | PATION | 155 KIND OF BUI | SINESS/INDUSTR | | | | |
| once. | (Specify only highest gradi Elementary/Secondary (0-12) | completed) College (1-4 or 5 +) | (Give kind of w | ork done durin | ng most of working | 100. KIND OF BO | SINESS/INUUS I N | , | | | |
| 1 | 1.2 | Homema | kor | | Orath | Home | | | | | |
| Once. | 17. FATHER'S NAME (First, Middle, Last) | | 11OMEMO | TCT. | 16 MOTHER'S NA | ME (First, Middle, Melden | | | | | |
| E O | James A. Fla | hertv | | | CONTRACTOR FOR | a Agnes He | | | | | |
| 8 8 | 19a, INFORMANT'S NAME (Type/Print) | 1 | 10h MAILINO | ADDRESS (S) | reet end Number or Rural i | | _ | | | | |
| TO BI | James H. Corey, J | r. | | | | | | le,NJ 08876 | | | |
| 2 | 20g, METHOD OF DISPOSITION | | | | | | | | | | |
| | 1 🖾 Buriel 2 🗆 Cremation 3 🗆 Ren | noval from State | cemetery, crematory or atl | er place) E | ebruary 1, | 1996 20c. LO | CATION — City o | | | | |
| | 4 Donation 6 Other (Specify) | | Arlington | | nal Cemete | | ington, | Virginia | | | |
| examiner must | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphre Home/Bethesda-Chevy Chase, Inc., | | | | | | | | | | |
| 970 | M00348 Wisconsin Ave., Bethesda, MD 20814-3501 | | | | | | | | | | |
| medical | 23. PART i. Enter the diseasea, or | compile tions that cau | sed the death. Do no | | | | | Approximata | | | |
| Ě | shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Finel Onest and Desth | | | | | | | | | | |
| | disease or condition | | | | | | | | | | |
| | resulting in death) | 8. DUE 10 (08.4 | EMOWING OF | | | | | 194/2 | | | |
| | | 10 (0.1.) | W V GOLIGE OF | | | | | ' ' | | | |
| CERTIFICATION | Sequentially list conditions, | DUE TO (OR A | AS A CONSEQUENCE OF | : | | | | | | | |
| ΑŢ | if any, leading to immediate cause. Enter UNDERLYING | | | | | | j | | | | |
| TIFIC | CAUSE (Disease or Injury that initiated events | DUE TO (OR A | S A CONSEQUENCE OF | : | | | | | | | |
| R | resulting in death) LAST | 2 | | | | | | | | | |
| 빙 | 0 | | | | | | | | | | |
| A. | PART ii. Other significant condition | ne contributing to deat | h but not resulting in | the under | lying cause given in | Part i. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS | | | |
| MEDICAL CE | - Hourose | in la | mc/10 005 | ala | Luge | 1 TES 2 | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| W | Markin | 1Stat S | \$150ARQ | | _ | | | OF DEATH? 1 YES 2 NO | | | |
| | DID TOBACCO USE CONT | | OF DEATH YE | I NO | □ UNCERTAIN | | | 1 153 7 7340 | | | |
| 1 × | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATI | | | • | | | | | |
| SICIAN | EXAMINER? FX YES 2 NO | HOSPITAL: | Admeticat 2 DOA | OTHER: | Home 5XXResidence | | | | | | |
| BY PHYS | 27. MANNER OF DEATH | 28e. DATE OF INJUI | | | NJURY AT | 28d. DESCRIBE HOW I | N ILIPY OCCUPED | | | | |
| | 1 K Natural 5 Pending | (Month, Day, Yea | ir) inju | RY | WORK? | 200. DESCRIBE HOW II | NJOH! OCCORED | | | | |
| B | 2 Accident Investigation 3 Suicide B Could not be | 28e. PLACE OF INJI | URY — At home, farm, at | | | COLLOCATION (C) | | 10 . 11 . | | | |
| | 4 Homicide B Could not be | building, etc. (S | Specify) | reet, ractory, | onice | 28f. LOCATION (Street e City or Town, Stete) | end Number of Hui | er Houte Number, | | | |
| ETE. | 29a, CERTIFIER WW | | | | | | | | | | |
| MPLE | (Check only | ICIAN: To the best of my kr | | | | | | | | | |
| O BE CON | 2 MEDICAL EXAMINA | On the beels of examina | ation and/or investigation | , in my opinio | on, death occured at the | time, date end place, en | nd due to the ceus | se(e) end manner ee stated. | | | |
| Ш | 296. SIGNATURE AND TITLE OF CENTURE | R | 0 | | 29c. LICENSE NUN | ABER | 29d. DATE SIGN | IED (Month, Day, Year) | | | |
| BE (| Bookin XTI | numi1 | 7 | | Alm | 311 | D 1/7 | 21/5/ | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | 10 COMPLETED CAUSE OF | DEATH (ITEM 27) (Types) | Print) | 10 - 1 | . / | 1/1/ | 1 1 | | | |
| | Datramin | H-VKUL) | In In | | 12/1 | Visine | Vh. | 111.16 | | | |
| | 31. DATE FIGED (Month, Day, Year) | 32, REGISTRAR'S S | IGNATURE | | 1019 | Picture | | The Contract of the Contract o | | | |
| | JAN 3 0 1996 | | or Roslall | | | | | | | | |
| | 0 0 0 1000 | | | | | | | | | | |
| الـــا | 27.1. 0 0 1000 | 0 | | | | | | DHMH-10 | | | |



8. BIRTHPLACE (State or Foreign Country)

Minnesota

Maryland

Specify:

1996

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 - YES 2 NO

White

Approximats

Interval Between

3 mm

24b WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

Onset and Death

4:14A

Pages 1, 2, 3 should

permit.

funeral director, page 5 should be detached for use as the burial-transit

W

notified

9

must

examiner

retained by the hospital or attending physician.

hours after death. Page 6 may be

100 medical

completely filled in by

in and com executed

attending physician ntal Hygiene prior to

signed by the atten Health and Mental A

been :

has b. Dept. 23

certificate h

this c marked.

After death

69 DIRECTOR: A hours after d item 28 is

cremation, or

the

event.

traumatic

other

6

Shows any

ВУ

COMPLETED

2

NER?

27. MANNER OF DEATH

1 Netural

2 Accident

3 Suicide

29a. CERTIFIER

4 Homicide

1 P YES 2 - NO CLEURED

8 Could not be

TITLE OF CERTIFIER

Loger

determined

BALTIMORE, MARYLAND 21215-0020

Raymond

4. SOCIAL SECURITY NUMBER

Charles

IF UNDER 1 YEAR

YRS.

IF UNDER 24 HRS.

4 Nursing Nome 5 Residence 8 Other (Specify)

29c. LICENSE NUMBER

44580

28d. DESCRIBE NOW INJURY OCCURED

281. LOCATION (Street end Number or Rural Route Number, City or Yourn, State)

29d. DATE SIGNED (Month, Day, Year)

> January

28c. INJURY AT

2
MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

1 YES 2 NO

HOURS

Tanuary

7. DATE OF BIRTH

TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT; If Item 21

Centur Prive, Suite 308, 6106er 9711 medicul 31. DATE FILED (Month, Day, Year) 22. REGISTRAR'S SIGNATURE 3 0 1996

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Inpatient 2 - ER/Outpatient 3 - DOA

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

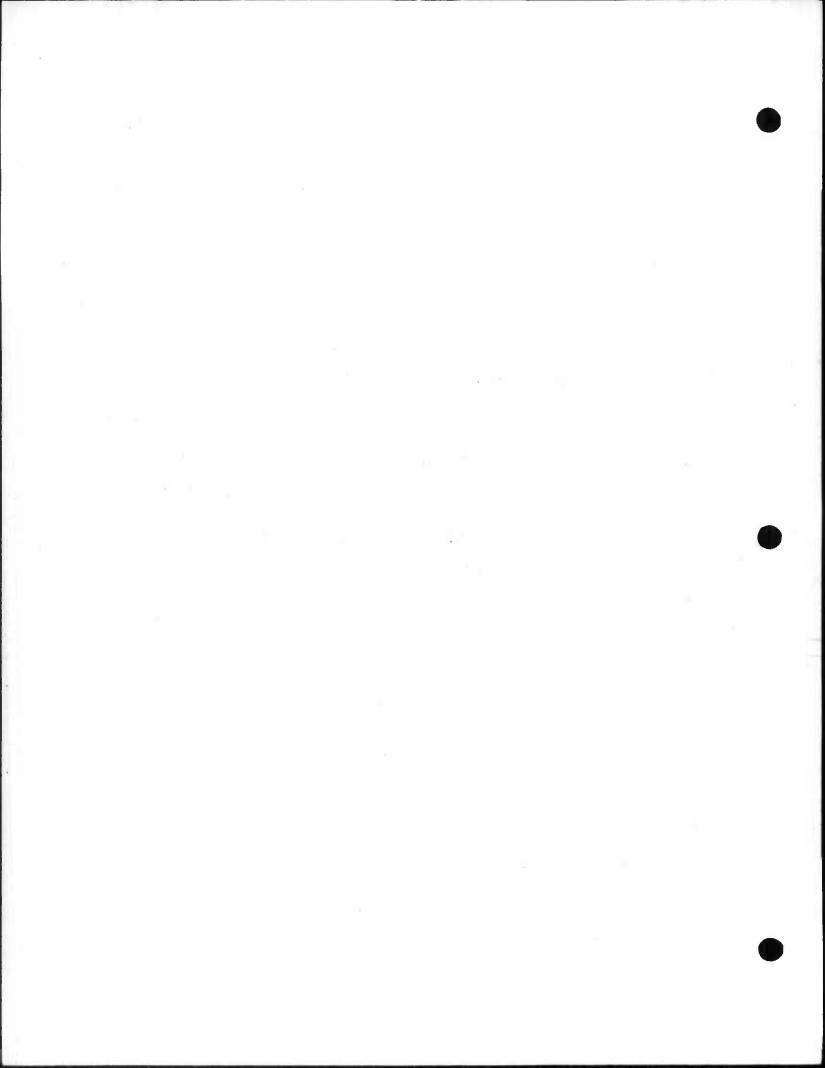
HOSPITAL:

28e. DATE OF INJURY (Month, Day, Year)

MO 20850

27, 1996

| | | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR | TMENT OF I | HEALTH AND | MENTA | NL HYGIEN | IE | 0 | 03 | 000 |
|---|---------|---|--|--|--|---|---|-------------------------------------|------------------------|---------------------|--------------|---------------------------------|
| | | t. DECEDENT'S NAME (First, Middle, Last) MARY JOSEP | HINE CU | MMIN | | | 2. DATE | E OF DEATH | MV N | EAR . | TIME OF D | |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (N | n yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | | E OF BIRTH | | | ACE (State o | |
| phods | | 577-14-9479 8e. FACILITY NAME (If not institution, give stre | 1 ☐ M 2 ဩ F | 93 YRS. | | OR LOCATION OF D | Apri | 11 20,1 | 902 W | | | n, D.C |
| 2, | CTOR | Brooke Grove Nu | rsing Home | | | y Spring | | | | tgome | | |
| Pages 1. | DIREC | 10a. STATE 10b. COUNTY | | 10c, CITY | 10c. CITY, TOWN OR LOCATION | | | | | tod. IN | | |
| permit. F | | Maryland Mont 10e. STREET AND NUMBER | gomery | | Bethesd | A. ZIP CODE | | | 10g. CITIZEN OF WHAT O | | | ⊠ NO |
| - IS | FUNERAL | 7616 Winterberry | | | | 20817 | | | | | State | |
| -AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once. | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DA | 2 XNO | If yes, s | CENDENT OF HISPA pecify Cuban, Mexic 8 2 NO Speci | IGIN? (Specify Yes or No— 14. RACE Black, rto Rican, etc.) 14. RACE Black, Specify | | | American Mite, etc. | | |
| r attend use as | ETED | 15. DECEDENT'S EDUCA (Specify only highest grade co | | (Give kind of w | DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | | |
| Spital or hed for | | Elementary/Secondary (0-12) | College (1-4 or 5+) | Deed Red | | Supervis | son V | Vashing | gton. I | o.c. | Gove | rnment |
| | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | _ | | | | | |
| retained by 5 should be notified at | 8 | James Will 19a. INFORMANT'S NAME (Type/Print) | iam Cummings | | ADDRESS (Street | and Number or Rural | | ary Eli | | | ene | |
| 2 5 5 2 | 5 | Mary Cregger | | R.D. 2 | , Box 7 | 8M, Clea | | | | | 1553 | 35 |
| | | 20a. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) | al from Stale 20b. | PLACE AND DATE Of the control of the | r DISPOSITION (N her place) | rv | DA1 | | CATION — CIT | | | |
| Page 1 | | 21 SIGNATURE OF FUNERAL PERVICE LICEN | | 11 | - V | ND ADDRESS OF F | CILITY | 30 Was | Funera | | | |
| after death. y the funera moval. Ical examin | Щ | Michael | 1 cel | den | 10 E.I | Deer Parl | c Dr. | . Gait | thersb | irg. | | 20877 |
| hours or re | | 23. PART I. Enter the diseases, or co- ahock, or heert failure. Lie IMMEDIATE CAUSE (Finel | npications that caused it only one cause on ea | the death. Do n ch line. | ot enter the mo | ode of dying, au | ch aa cer | diac or resp | Iratory arrea | t, | | dmate d Between and Death |
| within 24 within 24 release file cremation. | | disease or condition resulting in death) | ASPIRA | | PNE | MON | A | | | | 1.0 | AYS |
| 8 5 - 6 | z | | MULTIPLE | | | AL FI | NFF | +RCTS | > | | | |
| ficate be executionly solved to bunian to bunian er traumatic | CATION | Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEDUENCE OF): | | | | | | | | | |
| phy ne p | RTIFIC | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | | | | |
| e Held | CER | reaulting in death) LAST | | | | | | | | | | |
| ing the | EDICAL | PART II. Other algnificant conditions | contributing to deeth bu | t not resulting is | n the underlyin | g ceuse given in | Part I. | 24e. WAS AN PERFOR | RMED? | CO | AILABLE PRI | |
| requires hen sign of Hea | ≥ | DID TORACCO LICE COATTO | | | | 4 | | | | | DEATH? | □ NO |
| De ta | SIAN: | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 2 | 6. PLACE OF DEAT | | UNCERTAI | N L | L | | | - | |
| PHYSICIAN: The this certificate It with the State Invite the State Invited, or Item | IYSICI, | | OSPITAL: | | | ne 5 🗆 Residence | | | | | | |
| PHY this PHY | у РНУ | 1 Netural 5 Pending 2 Accident Investigation | 26e. DATE DF INJURY (Month, Day, Year) | 26b. TIME INJU | JRY WO | JURY AT DRK? YES 2 NO | 28d. DE | SCRIBE HOW I | NJURY OCCUP | RED | | |
| TTENDI TTENDI TTOR: A after da | TED B | 3 Suicide 6 Could not be determined | 26e. PLACE DF INJURY - building, etc. (Specif | At home, term, st | treet, lectory, offic | 0.0 | | CATION (Street a or Town, State) | and Number or | Rural Route | Number, | |
| 世 女 な 年 | COMPLE | 290. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | IN: To the best of my knowle On the basis of examination | | | | | | | euse(s) an | d menner r | ns stated, |
| TO THE HOSPI TO THE FUNER TO FILE WITHIN | BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| P P 2 W | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEAT | TH (ITEM 27) (Type, | Print) | F7771 | <u> </u> | | - - | 28 | -46 | 0 |
| | | TED E. HOWE. | MD 7 | 5420 | | K DR. | Box | ousbox | 20, M | Di | 2171 | 3 |
| | | JAN 3 0 1996 | 32 REGISTRAR'S GIGNAT | Rardall | | | | | | | | |



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | TIEGIOTIVAL | | | LITT | CAIL | . OF | DEAL | l III | F | REG. NO. | | | |
|---------------|--|---|---------------------------------------|---------------|----------------|------------|----------------|-------------|--------------------------|--------------------|-------------|-------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | | | | TIME OF DEATH |
| | 15 Ayest | - (| 47500 | . 0 | | | | | МОНТН | DA | W - | YEAR | 1210 " |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) | | | | | | | 2940 | | 11 | 1991 | 18110 M | |
| | | | | | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF (Month, De | BIRTH IV. Year) | | 8. BIRTHPL: Country) | ACE (State or Foreign |
| | 101 03 2196 | $01 \ 03 \ 2196$ $1 \ \text{$\times M} \ ^2 \ \Box \ F$ 80 YRS. MONTHS DAYS HOURS MIN. Sept. $28,1$ | | | | | 915 | New Y | ork | | | | |
| | 9a. FACILITY NAME (If not institution, give a | treet and number) | | | 9b. CITY | TOWN O | R LOCATIO | | | 20,1 | | NTY OF DEAT | |
| œ | Shady Grove Adven | | nital | | | kvi | | 011 01 02 | 2011 | | | ntgome | |
| 2 | RESIDENCE OF DECEDENT | CISC NOS | PICAI | | Littor | LVI | 110 | | | | 110 | II C G O III C | - L y |
| DIRECTOR | 10s. STATE 10b. COUNTY | | | | | | | | | | | | |
| 2 | | | | | Y, TOWN O | | ION | | | | | 10 | d. INSIDE CITY LIMITS? |
| | Maryland Mont | gomery | | P | otoma | 1C | | | | | | 1 | YES 2 NO |
| 7 | 10e. STREET AND NUMBER | | | | | 101 | ZIP CODE | E | | | 10a, CIT | IZEN OF WHA | T COUNTRY? |
| 3 | 7946 Turncrest Dr | ive | | | | | 208. | 54 | | | | | |
| FUNERAL | | | | | | | | | | | | ited S | States |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AF | MED | 13. V | MAS DEC | ENDENT O | F NISPAN | IC ORIGIN? (S | pecify Yes | or No- | 14. RACE - | American Indian, fhite, etc. |
| | 1 Never Married 2 Married | IF YES, GIVE V | | NO | | | 2 K NO | | n, Puerlo Rice | n, etc.) | | | |
| BY | 3 Widowed 4 Divorced | World W | ar II | | | _ | | , | | | | Specify: Wh | ite |
| | 15. DECEDENT'S EDU | | 18a, DE | CEDENT'S | USUAL OC | CUPATIO | IN. | - | 165 KH | ND OF BUS | INESS/IN | | |
| EI | (Specify only highest grade | | (G | live kind of | work done d | uring mo | st of workin | g | 100.14. | 15 01 500 | M14COO71141 | DOSTAT | 1 |
| ٦ | Elementary/Secondary (0-12) | College (1-4 or 5 | •) | | | | _ | | | | т . | 1 | |
| 8 | - | 1 | Dre | ss ra | tter | n Ma | iker | | Ga: | rment | Inc | lustry | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | - | | | 18. MOTH | NER'S NAI | ME (First, Midd | le, Maiden | Sumame) | | |
| | Francesco Carbon | e | | | | | Ann | unzi | ata G | razi | adei | | 4 |
| H | 19a. INFORMANT'S NAME (Type/Print) | | 40 | h MAH ING | ADDRESS | /Otor -1 - | | | Route Number, (| | | | |
| 2 | | | | | | | | | | | | | |
| | Ernest R. Carbone | | | _ | | _ | | | Poton | ac, | Mary | Tand Z | 10834 |
| | 20a. METHOD OF DISPOSITION 1 Sp Burial 2 ☐ Cremation 3 ☐ Remo | numi form State | 20b. PLACE cametery, cre MD Sta | ANDDATE | OF DISPOSI | TIONINA | me of 1 | 100 | OATE | 20c. LO | CATION - | City or Town, | State |
| | 4 Donation 5 Other (Specify) | ovar trotti otato | - MD Sta | ate V | etera | ins | Ceme | terv | 1 | Crow | nsvi | 11e. M | faryland |
| 1 | 21. SIGNATURE OF FUNERAL GERVICE WO | ENREE | | | 22. N | IAME AN | D ADDRES | S OF FAC | PALITY Rob | ort | Λ D | umphre | y Funeral |
| - 3 | NA | | 1400606 | | Hon | ne /R | ocky | i11e | Tnc | 300 | WAS | t Mont | gomery |
| 33 | 17774 L) / | W | M00689 | , | AVE | nile | - Ro | ckvi | ile, M | larv1 | and | 20850- | -2805 |
| | 23. PART L/Ester the disesses, or o | omplications tha | t caused the de | eth. Do r | ot enter | the mo | de of dvi | ng. such | as cerdiec | or respi | ratory an | rest | Approximata |
| | spoon or neart failure. | List only one ceu | se on sach line | в. | | | | | | о. тоор | | | Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | - / | // | | | | - | | | | | | Onset and Death |
| | resulting in death) | 1 lex | arro | 4 | ly | -7/- | her | -9 | | | | | 2×ns |
| | | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | |
| z | | 100 | cy to | ren | ia | | | | | | | | 200 |
| 2 | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSE | QUENCE OF | 7): | | | | | | | | |
| ₹ | cause. Enter UNDERLYING | 1 | | | | | | | | | | | 2 4 Nav |
| 유미 | CAUSE (Disesse or Injury | DUE TO | OR AS A CONSE | OLIENCE OF | D. | | | | | | | | 3 447 |
| Ē | that initiated events resulting in death) LAST | | (OII AD A CONSE | DOENCE OF | , / | | | 1. 6 | १ ८३ ४ | | | | |
| CERTIFICATION | | ه | 20701 | 7 6 | deve | 27 | | /() | (,) 4 | | | | (0)21 |
| - 11 | PART II. Other significant condition | s contributing to | deeth but not | reauttine i | n the une | darbular. | | drawn In I | Don't I at | | | | |
| EDICAL | C 4 | to | / July Hot I | eauting (| uie unc | aciving | cause g | iven in i | raft I. 246 | PERFOR | | | RE AUTOPSY FINDINGS VLABLE PRIOR TO |
| ¥ 1 | Chronic | Renal | to all | 171 | 4 | | ong, | 17 /2 | 207 11 | YES 2 | DNO | CO | MPLETION OF CAUSE DEATH? |
| | It ead | Faitur | 4 | | | | / | | | | 3 | | |
| Σ. | DID TOBACCO USE CONTE | | _ | TH V | SIL | ОП | HNC | ERTAIN | | | | 1 | YES 2 HO |
| A I | 25. WAS CASE REFERRED TO MEDICAL | COLL TO CA | | | N (Check o | | OIYC | LK IAII | <u>, ப] </u> | | | | |
| <u></u> | EXAMINER? | HOSPITAL: | 26. PLAC | E UF DEAL | OTHER | | | | | | | | |
| Z. | 1 TES 2 NO | 1 Sinpatient 2 | ER/Outpatient 3 | □ DOA | | | 5 🗆 Res | sidence | 8 Other (Sp | ec/fy) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF | | 28b. TIM | E OF | 28c. INJU | JRY AT | | 28d. DEŞCRI | BE NOW IN | JURY OC | CURED | |
| | 1 Natural 5 Pending | (Month, D | sy, rear) | INJ | URY | 1 V | 9K? E\$ 2 [| l NO | | | | | |
| B | 2 Accident Investigation | 28 - PLACE O | F INJURY — A1 ho | | | | | , | | | | | |
| 유내 | 3 Sulcide 8 Could not be 4 Homicide determined | building, | etc. (Specify) | ити, тактт, п | RITERY, TRICTO | ry, omice | | | City or To | N (Street al | nd Number | or Rural Route | Number, |
| COMPLETED | Total Total | | | | | | | | | | | | |
| ۱۱ ټ | 29a. CERTIFIER (Check only | CIAN: To the best of | my knowledge, de | ath occum | d at the tie | no dete | and place | and due | to the enues/s | \ and man | | | |
| Σ | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | |
| 8 1 | | | enwar | vangano | , п. п.у ор | | with Decure | ed at the 1 | mine, case and | hince, end | aue to th | re cause(s) en | u manner as stated. |
| | | | | | | | 29c. LICE | NSE NUM | BER | T | 294 DAT | E SIGNED /Ma | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | - / | | | | | | | | | | E GIGITED INC | inth, Day, Year) |
| 8 | 296. SIGNATURE AND TITLE OF CERTIFIER | EX2 | | | | | 10 | 14 | 660 | | 1 | Oran t | onth, Day, Year) |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO | EX. | SE OF DEATH (ITE | M 27) (Tvpn | Print) | | 10 | 14 | 660 | | 1 | anua | 781986 |
| H | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CHOS | SE OF DEATH (ITE | M 27) (Type, | Print) | | B | 14 | 660 | 20/ | 1 | anua | 7 8 1986 |
| H | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITE | M 27) (Туре, | Print) | u×. | 10 +F | 14 | 11 10 | ?«/ | 1 / Ca, | anua | 7 28 1986 28 1986 |
| 8 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | R'S SIGNATURE | M 27) (Type, | Print) | ω×. | 10 +F | 14 | 11 10 | ? d | 6 cm | anua the | 28/986 28/986 28/986 20/986 |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

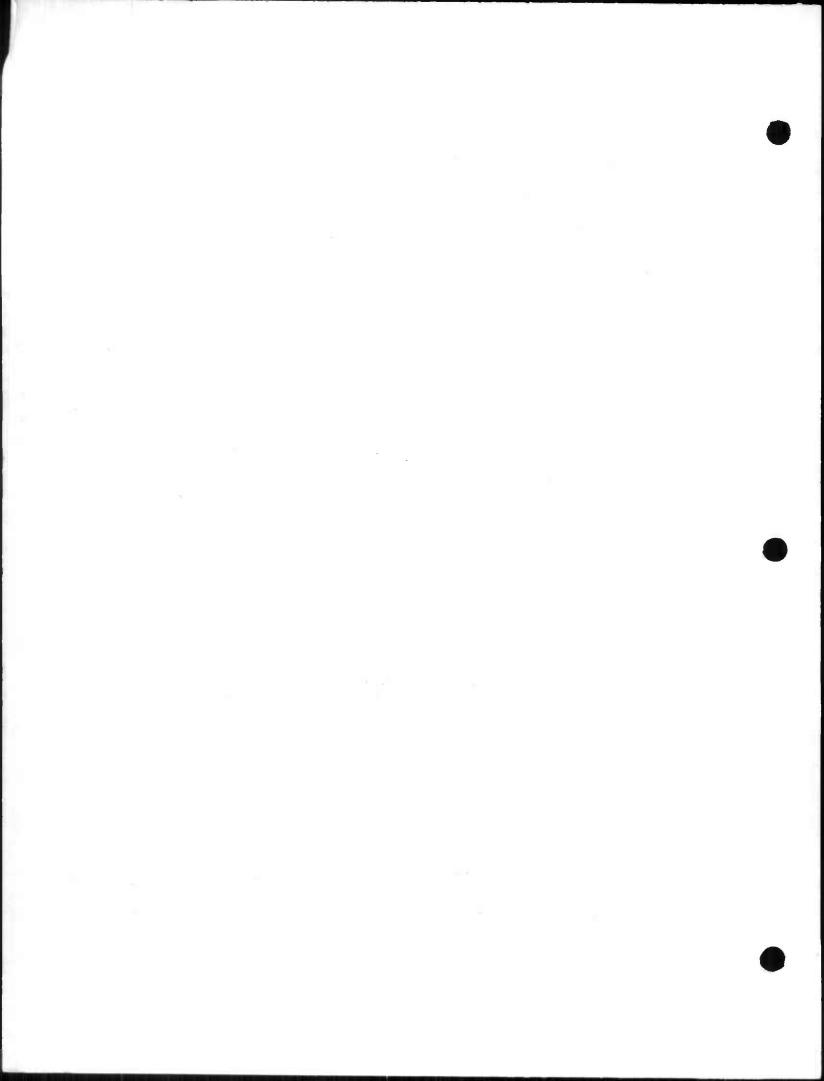
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

20 +1

DHMH-18 Rev 1/89

| L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wirthw. 24 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | urs after death w | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|-------------------|--|
| TO THE HOSPITAL OR ATTENDING PI | TO THE FUNERAL DIRECTOR: After th | r death w | mark |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMEN ERTIFICAT | | | | IENTAL HYGIEN | _ | | |
|---------------|--|---|---|---------------|--------------------|------------|---|---|---------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | O. CLA. | BORN | 12- | | | 2. DATE OF DEATH MONTH DA | | YEAR 3. | 3:15-PM |
| | 579-20-0318 | 6. AGE (In yrs. last | YRS. MONTHS | | IF UNDER | MIN. | 7. DATE OF BIRTH (Month, Day, Year) Dec. 19, 1 | 920 | Wa. | Sh. DC |
| OB | 98. FACILITY NAME (II not institution, give street Washington Adversariance of Decement | | | | oma coma | | | | NTGO | |
| DIRECTOR | 10a. STATE 10b. COUNTY | ce Georges | 10c. CITY, TOWN OR LOCATION | | | | | | 1936 | 1. INSIDE CITY LIMITS? XYES 2 \(\text{NO} \) |
| FUNERAL | 100. STREET AND NUMBER 5017 Lakeland | Road | | 101 | ZIP CODE | 740 |) | | S.A | COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 XMarried 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 X N IF YES, GIVE WAR OR DATES | | II yes, sp | | n, Mexicar | IC ORIGIN? (Specify Yea i, Puerto Ricen, etc.) | or No- | Bleck, Wi | American Indian, hits, etc. Black |
| PLETED | | mpleted) (Gi file. | cedent's usual ive kind of work don Do NOT use retired Secreta | e during mo | | g | Pr. Ge | | | ls |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) William Brooks | 7250 | | 1 | | | AE (First, Middle, Meiden Butler | Surname) | | |
| TO BE | 19e. INFORMANT'S NAME (Type/Print) James L. Claibo | orne (Husband | . MAILING ADDRE | ss (Street I | nd Number kelai | or Rural A | Rd., Col | n, State, Zip Lege | °Park | , MD |
| | 20e. METHOD OF DISPOSITION t (\ Burlei 2 \ Cremetton 3 \ Hamber 4 \ Donation 5 \ Other (Specify) | 20b. PLACE | AND DATE OF DISPO | OSITION (N | me of | | OATE 20c. LO | 20c. LOCATION - City or Town, State Bladensburg, MD | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | Inevdu | | SNO | VDEN | FU | VERAL HO | | P.A. | |
| | | mblicetions that coused the de st only one cause on each lins FUNGAL | | | | ng, auch | aa cardiac or reap | fretory arre | et, | Approximata Interval Batween Onset and Death |
| - | disease or condition resulting in death) | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSECUENT OF TO (OR AS A CONSECUENT) | OUENCE OF): | | | | • • | | | |
| | PART II. Other algnificant conditions | contributing to death but not r | resulting in the | underlyln | g ceuse g | given in | Part I. 24a. WAS AN PERFO | RMED? | AW | RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE |
| V: MEDICA | CONGESTIVE CHRONIC REN DID TOBACCO USE CONTRI | | | | | | | 2 NO | OF | OEATH? |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLAC IOSPITAL: A inpatient 2 - ER/Outpatient 3 | CE OF GEATH (Chec | ER: | | eldence | 6 Other (Specify) | - | | |
| ву рну | 27. MANNER OF DEATH 1 Nstural 5 Pending 2 Accident Investigation | 28e. OATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 28c. IN | JURY AT DRK? | | 28d. DESCRIBE HOW | INJURY OCC | URED | |
| ETED B | 3 Suicide 6 Could not be 4 Homicide determined | 26s. PLACE OF INJURY — At he building, etc. (Specify) | eme, tarm, atreet, fi | actory, offic | 20 | | 261. LOCATION (Street City or Town, State | | or Rural Rout | e Number, |
| COMPLE | Criedic only | AN: To the best of my king-redge, do On the besis of examination analor | | | | | | | | nd menner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Pacion | | | 29c. LICE D 3 | ENSE NUN | IBER 7/7 | ≥ JA | SIGNEO (MO | onth, Day, Year) H 1978 |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | DRI- 4700 BE | M 27) (Type, Print) RWYN + | foust | R | D, | College | PAK | RK H | 1)20740. |
| | JAN 31 1996 | 32. REGISTRAR'S SIGNATURE | | | | | | | | 1 |

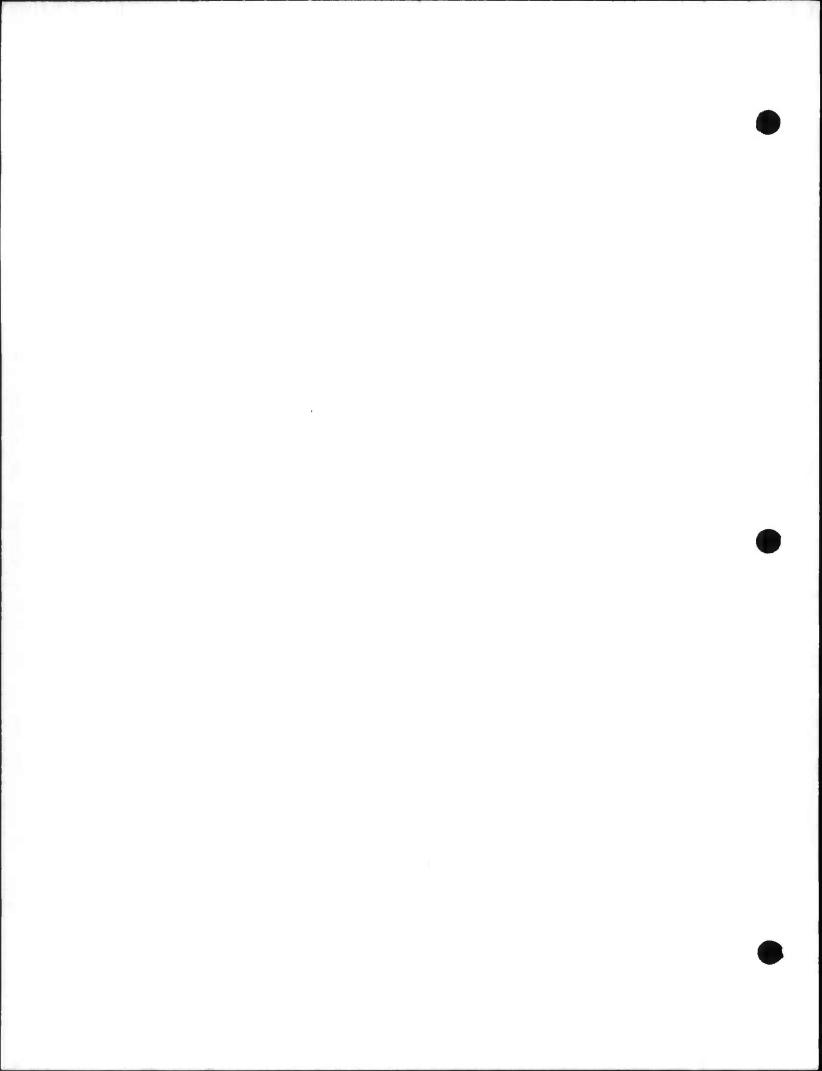


ospital or attending physician. she burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | y the hosp | be detached | at once. | |
|--|-----------------|--------------------------------------|---------------|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be | e retained | 5 should | notified | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pag TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dip of filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner | e 6 may b | rector, pag | must be | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene pror to burial, cremation, or remova IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical | death. Pag | funeral di | examiner | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 124 ID THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the | hours after | or removal | medical | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and combe filed within 72 hours after death with the State Dept. of Health and Mental Hyglere prior to burial, IMPORTANT: If I Item 28 is marked, or Item 23 shows any Injury, or other traumatic expension. | within 24 | pletely fille cremation. | rent, the | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate by THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physicis be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other tra | e executed | an and con | umatic e | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of the FUNERAL DIRECTOR: After this certificate has been signed by the attend be filed within 72 hours after death with the State Dept. of Health and Mental HIMPORTANT: If I tem 28 is marked, or Item 23 shows any injury, or | sertificate b | ing physici valene prio | other tra | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that TO THE FUNERAL DIRECTOR. After this certificate has been signed by be filed within 72 hours after death with the State Deft. of Health an IMPORTANT. If Item 28 is marked, or Item 23 shows any | the death of | the attend | Injury, or | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law red TO THE FUNERAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of IMPORTANT: If I tem 28 is marked, or Item 23 sh | juires that | signed by Health and | ows any | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN; I TO THE FUNERAL DIRECTOR: After this certificat be filed within 72 hours after death with the Stat IMPORTANT: If I tem 28 is marked, or ite | he law red | e has been | m 23 sh | |
| TO THE MOSPITAL OR ATTENDING PHYSIS TO THE FUNERAL DIRECTOR. After this or be filed within 72 hours after death with IMPORTANT. If Item 28 is marked, | CIAN: 1 | ertification the State | or ite | |
| TO THE HOSPITAL OR ATTEN TO THE FUNERAL DIRECTOR: be filed within 72 hours after IMPORTANT: If Item 28 is | DING PHYSI | After this co | s marked, | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | OR ATTEN | DIRECTOR: hours after | item 28 is | |
| | TO THE HOSPITAL | TO THE FUNERAL be filed within 72 | IMPORTANT: IF | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTI | MENT OF HEALTH A | ND MEI | NTAL HYGIEN | E | |
|--------------------|--|---|---|---|---------------------------------------|--|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | CHARLENE LYN | NETTE CHA | VOYA | 2. J. | DATE OF DEATH | 3 1996 YEAR | 3. TIME OF DEATH 1:43 PM |
| | 4. SOCIAL SECURITY NUMBER 585-22-3013 | 1 □ M 2 🗵 F 47 | | F UNDER 1 YEAR IF UNDER 24 ONTHS DAYS HOURS | MIN. | DATE OF BIRTH (Month, Day, Year) PRIL 10,1 | Count | HPLACE (State or Foreign ny) MEXICO |
| TOR | 9a. FACILITY NAME (If not institution, give at NATIONAL INSTITUTE | | | ETHESDA | OF DEATH | | 9c. COUNTY OF D | ERY |
| DIRECTOR | 10a. STATE 10b. COUNTY TEXAS DALLA. | S 10c. CITY, TOWN OR LOCATION DALLAS | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 3216 SAN VACANTE | | 101. ZIP CODE 75228 | | | 10g. CITIZEN OF V | WHAT COUNTRY? | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 [X] NO | 13. WAS DECENDENT OF If yes, specify Cuben, 1 YES 2 NO | HISPANIC O Mexican, Pu Specify: | PRIGIN? (Specify Yes | rs or No— 14. RACE — American Indian, Black, White, etc. CAUCASIAN | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5+) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n SUPERVI | done during most of working otired.) | | 16b. KIND OF BUS | TELEPHO | NE |
| MO | 17. FATHER'S NAME (First, Middle, Last) | 4 | SUPERVI | | R'S NAME (| First, Middle, Maiden | | NE |
| BEC | CHARLES W. UPSHA | W | | | | | RITE MORR | 20W |
| 01 | 19a. INFORMANT'S NAME (Type/Print) | | | DRESS (Street and Number or | | | | |
| - | JACKIE UPSHAW 200. METHOD OF DISPOSITION | | | RSINO COURT, | S.E, | | | |
| | 1 Burial 2 Cremation 3 Removed 4 Donation 6 Other (Specify) | val from State SUN | PLACE AND DATE OF I fery, crematory or other ISET MEMO | place) RIAL PARK | 1/ | | CATION — CITY OF TO IQUERQUE, | |
| | 21. SIGNATURE OF EUNERAL SERVICE LICE | MEER Tallels | 2 | 22. NAME AND ADDRESS ROBERT J. 4510 WILSO | MURPH | Y HY FUNERA | AL HOME, I | NC. |
| CERTIFICATION | 23. PART I. Enter the diseases, or co shock, or haert failure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events. | DUE TO (OR AS A C | CONSEQUENCE OF): | er Coller sky | y, such as | cardiac or respir | ratory arrest, | Approximata Interval Between Onset and Death 30 / 3 / K s |
| | PART II. Other significant conditions | contributing to deeth but | t not resulting in t | ha undariving cause giv | ran in Part | I. 24e. WAS AN | ALTTOREY TO ALL | WERE AUTOPSY FINDINGS |
| PHYSICIAN: MEDICAL | | | | The dilucitying cause giv | | PERFOR | MED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 2 | DID TOBACCO USE CONTR | IBUTE TO CAUSE OF | DEATH YES | □ NO □ UNCE | RTAIN [| al ' | | 1 TYES 2 NO |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | . PLACE OF DEATH | | | | | |
| IXSI | 1 VES 2 NO | 1 Inpatient 2 ER/Outpat | fent 3 DOA 4 | THER: Nursing Home 5 Reald | dence 6 🗆 | Other (Specify) | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME O | | | I. DE\$CRIBE HOW IN | NJURY OCCURED | |
| | 3 Suicide 6 Could not be detarmined | 26a. PLACE OF INJURY — building, atc. (Specify | – At home, ferm, street) | et, factory, offica | 281. | City or Town, State) | nd Number or Rural F | loute Number, |
| COMPLETED | | IAN: To the best of my knowled: On the basis of examination a | | | | | |) and manner as stated. |
| ᆲ┃ | 29b. SIGNATURE AND TITLE OF CERTIFIER | NAGNER | | 29c. LICENS | SE NUMBER | | 29d. DATE SIGNED | (Month, Day, Year) |
| 일 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEAT | | CKVILLE PIKE | , BET | HESDA. M | ARYLAND | 20892 |
| | JAN 2 9 1996 | 32. REGISTRAR'S SIGNAT | URES Charlett | | | | | |



BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 00 A JAN. 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday MONTHS DAYS HOURS 1)(X)(M 2 | F YRS 129-36-0233 49 Aug. 1946 New York Se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington Adventist Hospital DIRECTOR Takoma Park Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY Maryland Prince George's Hvattsville 1 YES 2 X XNO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP COOF 6500 Riggs Road 20783 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whita, etc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1 Never Married 2 Married BY 3) Wildowed 4 Divorced Black 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+) 10 Laborer Construction 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unavailable Ruby Irene Cox BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3900 Watson Place, #A4D, Lee A. Carty 20016 Washington, DC 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 X Cremation 3 ☐ Ramoval from Stata
4 ☐ Donation 6 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE netery, crematory or other place) Chesapeake Crematory 1-26 Beltsville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. leen 933 Gist Avenue, Silver Spring, MD 20910 23. PART I. Enter the diseases, or complications that cadeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between Onsat and Death IMMEDIATE CAUSE (Finel disease or condition_ resulting in death) M AS A CONSEQUENCE OF PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the junderlying cause given in Pert I. 24e. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 TE OF DEATN? 1 TYES 2 1 NO UNCERTAIN E DID TOBACCO USE CONTRIBUT TO CAUSE OF DEATH YES' N 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check or HOSTITAL: 1 YES 2 THO 1 Supportion 2 ER/Outpetlent 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural Pending 1 YES 2 NO BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide detarmined daeth occurred at the time, data and place, and due to the cause(a) and manner as stated.

> D., 6201 Greenbelt Road, #U-1, College Park, MD 20740

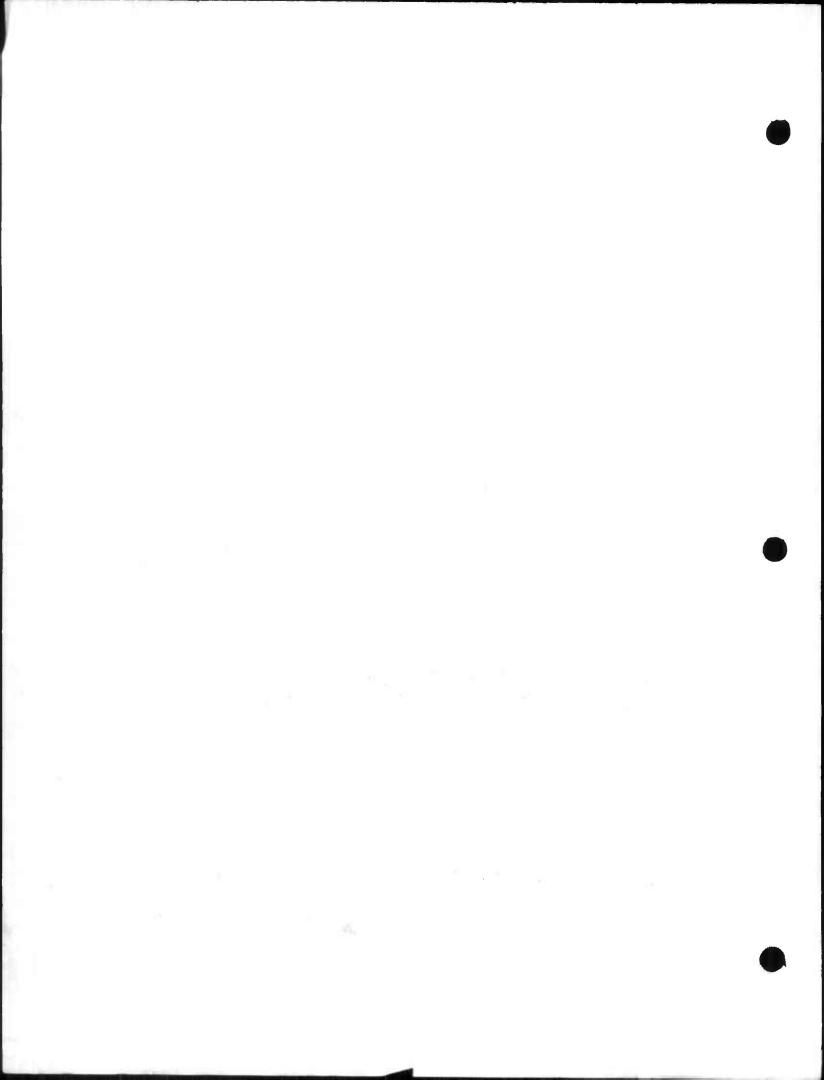
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JAN 3 0 1996 32. DEGISTRAR'S SIGNATURED

30. NAME AND AODRESS OF PERSON WNO COMPLETED CAUSE OF CEATN (ITEM 27) (Type, Print)

Μ.

Lewis H. Dennis,



detached for use as the burlal-transit permit, Pages 1, 2, 3 should

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4 Homicide

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| REC | equire | en sig | of Hea | shows |
| 7 | WE S | has be | Dept. | 23 |
| E | N. T | cate | State | Te T |
| > | CIA | entil. | the | 0 |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi | h with | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, th |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 27 3. TIME OF DEATH 1996 NORMA TALMADGE DAVIS 2344 January 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER I YEAR IF UNDER 24 HRS. April 29, 579 12 5032 1 M 2 XF 76 1919 YRS. 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT RESIDENCE OF DECEDENT 10e. STATE 18b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Calvert Lusby 1 YES ZE NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 370 Red Cloud Rd. 20657 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, atc.) Specify: 1 YES XXNO Specify white BY 3 Widowed 4 Divorced COMPLETED t6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify o Elementery/Secondary (0-12) College (1-4 or 5+) Beautician Hair Care 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas Howard Davis Florence Estelle Litchfield BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Linda S. Lovett same as 10 above 20s, METHOD OF DISPOSITION
1 & Burlel 2 Cremation 3 Genoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Cedar Hill Cem. 4 Donation 5 Other (Specify) 1 - 30 + 96Suitland, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Owings, Chay 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fallura. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final Obstructive Palenonan disease or condition resulting in death) bronk DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentistly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avents resulting in dasth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL OTHER: 1 YES 2 1-HO Inpatient 2 - ER/Outpatient 3 4-50A 4 Nursing Home 5 Rasidence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 27. MANNER OF BEATH 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation В 2 Accident 28a. PLACE OF INJURY — At homa, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED

29e. CERTIFIER

(Charle and)

(CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and menner as stated. 295 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

mother

MUKESH MATHUR, M.D.

PRINCE FREDERICK, MD. 20678

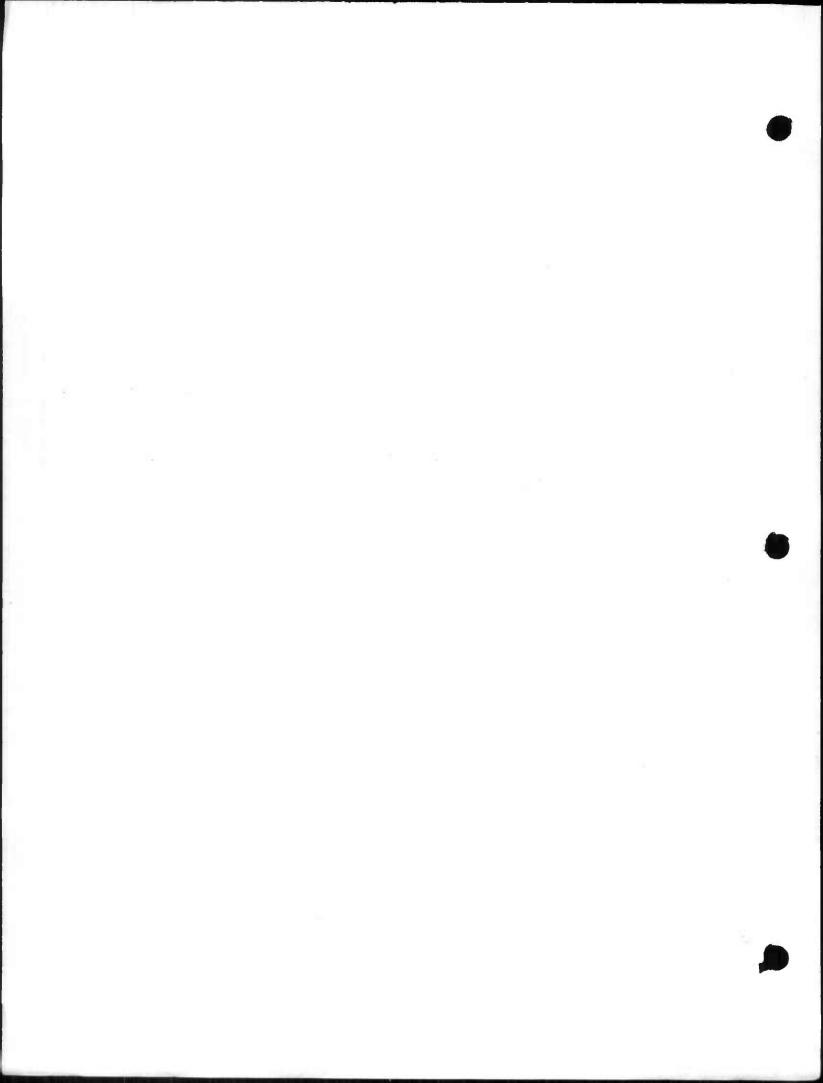
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31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE JAN 3 0 1996

Julia Davilson Rardall

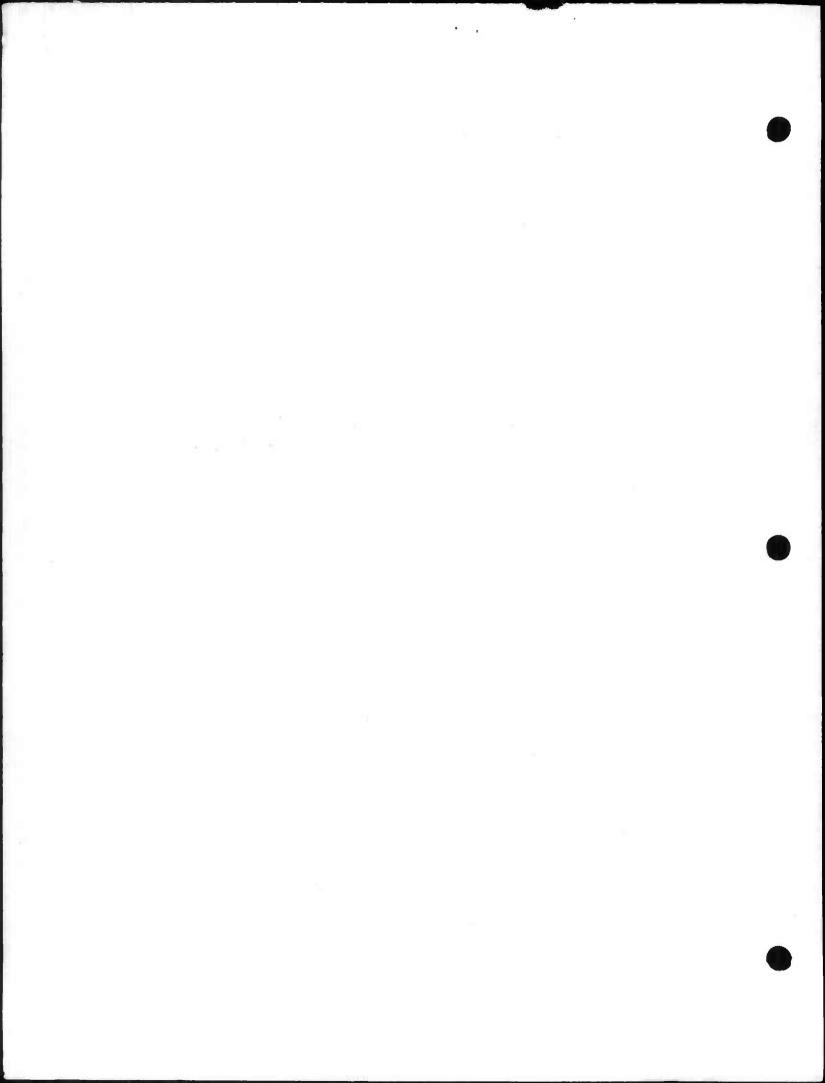
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DIVISION OF VITAL RECORDS, P.O. BOX 68761

| IYSICIAN: The law requires that the death certificate be executed within 2. | 10 THE FUNEMENT, UMBECION. After this certificate has been signed by the attending provided and chinipetery lined in by the funerial preciou, page is should be detached for use as the buna-transmit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memfal Hyglene prior to bunial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|--------------------|---|--|--|---------------------|--------------------------------|--|---|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEATH MONTH DA | | 3. TIME OF DEATH | |
| | LEON D DESKIN | SKINS | | | | | 1996 | 0945 M | |
| | | | (in yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | THPLACE (State or Foreign ntry) | |
| | 370 01 3413 | M 2 □ F 79 | YRS. | | | June 1 1 | 916 Oh: | | |
| œ | 9a. FACILITY NAME (If not institution, give street | and number) | | 9b. CITY, TOWN | OR LOCATION OF D | EATH | 9c. COUNTY OF | DEATH | |
| Ď. | CALVERT MEMOR | LIAL HOSPIT | AL. | PRINCE | FREDERI | CK | CALVER | P | |
| DIRECTOR | Maryland Calve | rt | 10c. CITY Lus | TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? XX 1 YES 2 NO | |
| AL | 10e. STREET AND NUMBER | | | 10 | I. ZIP CODE | | 10g. CITIZEN O | WHAT COUNTRY? | |
| EB | 8259 Sycamore | Road | | | 206 | 57 | Unite | ed States | |
| BY FUNERAL | 11. MARITAL STATUS 12 1 Never Married 2. Married 3 Widowed 4 Divorced | P. WAS DECEDENT EVER IF FORCES? 1 2 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | | NIC ORIGIN? (Specify Yea an, Puarto Rican, etc.) fy: | BI | CE — American Indian, ack, Whita, etc. | |
| COMPLETED | 15. OECEDENT'S EDUCATI (Specify only highest grade com Elementary/Secondary (0-12) | | 16a. DECEDENT'S I (Give kind of w life. Do NOT use | rork done during me | | 166, KIND OF BUS | SINESS/INDUSTRY | | |
| MPL | 12 | | Bus dr | river | | D.C. T | ransit | | |
| 00 | 17. FATHER'S NAME (First, Middle, Last) | | | | | AME (First, Middle, Maiden | Surname) | | |
| BE | John Deskins | | | | | Martin | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | inc | | | | Route Number, City or Tow | | 20657 | |
| | Margaret M. Desk | | . PLACE AND DATE O | | | Lusby Ma | | | |
| | 150 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | from Stata | netery, crematory or off Ir Lady | Star S | fanuary | 31 1996 Sea | Solon | Town, State Maryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY RAUSCH FUNERAL HOME. PA 4405 Broomes Is. Rd. Port Republic MD | | | | | | | | |
| | > Braus | x | | 4405 | Broome | s Is. Rd. | Port | Republic Mb | |
| NO | 23. PART i. Enter the diseases, or com shock, pr heart feilure. List IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | OS O (Q) | CONSEQUENCE OF | lumonia n: | ode of dying, suc | ch as cardiac or reapi | iratory arreat, | Approximate interval Between Onset and Daath | |
| CERTIFICATION | d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| N. | DID TOBACCO USE CONTRIB | | OF DEATH YE | | UNCERTAI | N 🗆 | | | |
| ICI/ | | QSPITAL: | | OTHER: | | | | | |
| | 27. MANNER OF DEATH 1 K Netural 5 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME | E OF 26c, IN. | JURY AT DRK? YES 2 NO | 6 Other (Specify) 26d. DESCRIBE HOW I | NJURY OCCURED | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be detarmined | Investigation 6 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. | | | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER: C | | | | | | | e(a) and manner as stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C | OMBI ETED CAUSE AT ST | ATM //TEM OR /Z | Deine | 29c. LICENSE NU | 314 | | ED (Month, Day, Year) | |
| | | | | | יוט ד מיזרוי | MD 20679 | | | |
| | 31. DATE FILED (Month, Day, Year) | 22 DECISEDADIS SICA | LATURE | LINCE PRE | IDEKTCK, | MD 20678 | | | |
| | JAN 3 0 1996 | Julia Davil | war Rardall | | | | | | |



BALTIMORE, MARYLAND 21215-0020

iours after death. Page 6 may be retained by the hospital or attending physician. It is by the funeral director, page 5 should be detached for use as the humal-based DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completed.

| mended | #16a, | #16b, | 1/24/96, | B.P., | WORCESTER | CO. |
|--------|-------|-------|--------------|-----------|---------------|-----|
| FOR | | | STATE OF MAR | OVI AND / | DEDARTMENT OF | 100 |

| | 1 - STATE STATE OF | | TMENT OF HEALTH AND ICATE OF DEATH | MENTAL HYGIENE REG. NO. | | |
|-------------------|--|--|--|--|---|--|
| 3 | | iryden | | 2. DATE OF DEATH DAY 99 | 6 YEAR 7:15 A | |
| - | 4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 TF 9e. FACILITY NAME (If not institution, give street and number) | 6. AGE (In yrs. lest birthday) 73 YRS. | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHE DAYS HOURS MIN. e | 7. DATE OF BIRTH (Month, Day, Year) Sept. 8, 192 | | |
| CTOR | . 924 Second Street | | Pocomoke Cit | Garage State | rcester | |
| - DIRECTOR | Maryland Worcester | | comoke City, | Md. | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 924 Second Street | | . 21851 | Un | ited States | |
| B⊀ | 1 Never Merried 2 Merried FORCES? | NT EVER IN U.S. ARMED 1 YES 2 W WAR OR DATES | 13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexico , 1 YES 2 NO Specify | NIC ORIGIN? (Specify Yes or No— on, Puerto Rican, atc.) | t4. RACE — American Indian, Black, White, etc. | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elements (Secondary (0-12) College (1-4 or 5 | (Give kind of w life. Do NOT use | USUAL OCCUPATION Nork done during most of working e retired.) | 16b. KIND OF BUSINESS/N | | |
| COMP | 17. FATNER'S NAME (First, Middle, Last) | Leber | 18. MOTNER'S NA | ME (First, Middle, Meiden Surneme | Poultry | |
| TO BE | Charles McBride 190. INFORMANT'S NAME (Type/Print) | | ADORESS (Street and Number or Rural | Route Number, City or Town, State, . | | |
| | Anthony McBride 20a METHOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Removal from State | 20b. PLACE AND DATE O | | DATE 20c. LOCATION | City, Md 2185 | |
| | 4 Donation 5 Opther (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 2 Q | 22. NAME AND ADDRESS OF FA | | oke City, Md. al Home P.O. | |
| CAL CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | O (OR AS A CONSEQUENCE OF |); | e renal | Interval Batwonest and Da | |
| : MEDICAL C | PART II. Other algnificant conditions contributing to Parisheral Vas La Cus. DID TOBACCO USE CONTRIBUTE TO CA | na st | oke | PERFORMEO? | Y 24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? t YES 2 NO | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF DEAT | OTHER: | | | |
| ву рну | 27. MANNER OF/DEATH 28e. DATE OI (Month, I | INJURY 26b. TIME | OF 26c. INJURY AT | 8 Other (Specify) 26d. OEŞCRIBE HOW INJURY O | CCUREO | |
| ETED 8 | 2 Naccident Investigation 3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 26e. PLACE OF INJURY — At home, term, street, factory, office City or Town, Street and Number or Rural Route Number, City or Town, Street | | | | | |
| COMPLE | 29e. CERTIFIER (Check only one) 1 CERTIFYINO PNYSICIAN: To the best of company one) 2 MEDICAL EXAMINER: On the bests of company one of the company of the co | | | | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | SE OF DEATH (ITEM 27) (Type, | 29c. LICENSE NUN H42 | 9// 29d. D/ | ATE SIGNED (Month, Day, Year) | |
| 3 | 500 markets | AR'S SIGNATURE | moke, 1 | 40 218 | 57 | |

. . . . · 3 ç == а. * | on the state of

| BALTIMORE, MARYLAND 21215-0020 | rours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. | medical examiner must be notified at once. |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: Il item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | | | | | |
|--------------------|--|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH | 3. TIME OF DEATH | | | | | | | |
| - 1 | Lena W. Doss | 01 25 | 1996 3:00 P M | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign | | | | | | | |
| | 212-24-9045 1 \(\text{1} \) M 2 \(\text{T} \) F \(\text{80} \) YRS. \(\text{MONTHS} \) DAYS HOURS MIN. | (Month, Day, Year) 11/24/1915 | West Virginia | | | | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF I | | COUNTY OF DEATH | | | | | | | |
| DIRECTOR | 32493 Rehobeth Road Pocomoke City | | Somerset | | | | | | | |
| EC | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | | | |
| | Maryland Somerset Pocomoke City | | 1 YES 2 1 NO | | | | | | | |
| FUNERAL | 10e. STREET AND NUMBER 10f. ZIP CODE | 10g | CITIZEN OF WHAT COUNTRY? | | | | | | | |
| EB | 23450 Rehobeth Road 21851 | | USA | | | | | | | |
| 5 | | ANIC ORIGIN? (Specify Yas or No | - 14. RACE — American Indian, Black, White, atc. | | | | | | | |
| BYF | 1 □ Never Merried 2 □ Married FORCES? 1 □ YES 2 ♠ NO If yes, apecify Cuban, Mexic 3 ☑ Wildowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2 ☑ NO Specific Cuban, Mexic 1 □ YES 2 ☑ NO Specific Cuban, Mexic | | Conceller | | | | | | | |
| | | | White | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINES | S/INDUSTRY | | | | | | | |
| Щ | Elementery/Secondary (U-12) College (1-4 or 5 +) | | | | | | | | | |
| MP | 8 Poultry Grower | | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S N | NAME (First, Middle, Melden Surna | ne) | | | | | | | |
| BE | | Kenneson | | | | | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rura | al Route Number, City or Town, State | e, Zip Code) | | | | | | | |
| - | William H. Doss 32493 Rehobeth Road, | Pocomoke City | , Md. 21851 | | | | | | | |
| | 20a. METHOD OF DISPOSITION X Burlat 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) | | N — City or Town, State | | | | | | | |
| | 4 Donation 5 Other (Specify) Bel Air Memorial Gardens, Inc. | | Maryland | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF F Melson Funera | FACILITY 1 HOME | | | | | | | | |
| | Scott S. Melson PO Box 64, Po | | MA 21851 | | | | | | | |
| | 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, au | ich aa cardiac pr respirator | y arreat, Approximate | | | | | | | |
| | ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): | | Interval Batween Onset and Death | | | | | | | |
| _ ! | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | |
| AT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| FIC | CAUSE (Disease or Injury that Initiated avents Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| F | resulting in death) LAST | | | | | | | | | |
| S | | | | | | | | | | |
| DICAL | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in | Part I. 24a. WAS AN AUTO PERFORMED? | AMILABLE PRIOR TO | | | | | | | |
| ME | | | 1 - YES 2 PNO | | | | | | | |
| Ë | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTA | IN 🗆 | | | | | | | | |
| ⋖ | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| ನ | FYAMINER? | | | | | | | | | |
| SICI | EXAMINER? 1 YES 2 PNO | 8 Other (Specify) | · · · · · · · · · · · · · · · · · · · | | | | | | | |
| HYSICI. | 1 VES 2 PNO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 PResidence 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME WORK? | 8 Other (Specify) 28d. DESCRIBE HOW INJURY | / OCCURED | | | | | | | |
| Y PHYSICIAN: MEDIC | 1 UPS 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 1 Netural 5 Pending 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? M 1 UPS 2 NO | | COCCURED | | | | | | | |
| BY | 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No. | / | | | | | | | |
| ED BY | 1 YES 2 PNO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 PResidence 27. MANNER OF DEATH 1 Netural 5 Pending Investigation Pending | 28d. DESCRIBE HOW INJUR | / | | | | | | | |
| ED BY | 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office 28e. CERTIFIER Representation 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. CERTIFIER Representation 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. CERTIFIER Representation 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. CERTIFIER Representation 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. CERTIFIER Representation 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. CERTIFIER Representation 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at rest, factory, office 28e. PLACE OF INJURY — At home, ferm, at r | 28d. DESCRIBE HOW INJURY 281. LOCATION (Street and Nu. City or Town, State) | imber or Rural Route Number, | | | | | | | |
| ED BY | 1 YES 2 PNO | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No City or Town, State) | imber or Rural Route Number, | | | | | | | |
| COMPLETED BY | 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY NORK? 1 YES 2 NO 28. PLACE OF INJURY — At home, ferm, street, factory, office 28e. PLACE OF INJURY — At home, ferm, street, factory, office 29e. CERTIFIER Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and during 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the street 1 MEDICAL EXAMINER: On the best of examination and/or investigation 1 MEDICAL EXAMINER: On the best of examination and/or investigation 1 MEDICAL EXAMINER: On the street 1 MEDICAL EXAMINER: On the best of examination 1 MEDICAL EXAMINER: On the street 1 MEDICAL EXAMINER: On the | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No. City or Town, State) use to the cause(s) and manner and time, data end place, and due | stated. to the ceuse(s) and manner as stated. | | | | | | | |
| COMPLETED BY | 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY WORK? 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the content of the property of | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No City or Town, State) us to the cause(s) and manner a ne time, data end place, and dua UMBER 29d. | imber or Rural Route Number, | | | | | | | |
| BE COMPLETED BY | 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY Y WORK? 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the time, date and pleca, and during the destination and/or investigation, in my opinion, death occurred at the time. | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No City or Town, State) us to the cause(s) and manner a ne time, data end place, and dua UMBER 29d. | stated. to the ceuse(s) and manner as stated. | | | | | | | |
| COMPLETED BY | 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the 11th occurred at the time, date and place, and ducence of the description of the beele of exemination and/or investigation, in my opinion, death occurred at the 11th occur | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No City or Yourn, State) us to the cause(s) and manner a the time, data end place, and due UMBER 29d. | e stated. to the ceuse(s) and manner as stated. DATE SIGNED (Month, Day, Year) | | | | | | | |
| BE COMPLETED BY | 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY WORK? 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the street 1 YES 2 NO 29b. SIGNATURE AND TILE OF CERTIFIER 29c. LICENSE NI YES 2 NO 30. NAME AND ADDRESS OF ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typs, Print) Ritchie C. Shoemaker, MD - 1604 Market Street, Pocome | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No City or Yourn, State) us to the cause(s) and manner a the time, data end place, and due UMBER 29d. | stated. to the ceuse(s) and manner as stated. | | | | | | | |
| TO BE COMPLETED BY | 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the 11th occurred at the time, date and place, and ducence of the description of the beele of exemination and/or investigation, in my opinion, death occurred at the 11th occur | 28d. DESCRIBE HOW INJURY 28f. LOCATION (Street and No City or Yourn, State) us to the cause(s) and manner a the time, data end place, and due UMBER 29d. | e stated. to the ceuse(s) and manner as stated. DATE SIGNED (Month, Day, Year) | | | | | | | |

1 10 (3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

| | 6 | Ω | 2 | 5 | 8 | (|
|---|---|---|---|---|---|---|
| 1 | U | U | U | U | U | 4 |

| 457 | | | | | Certifica | te of Death | Re | g. No. | | |
|--|-----|---|--|--|--|---|---|---|--|---|
| | | . Decedant's Nama (First, Middla, Las | st) | | | | 2. Data of Daath Month | Day | Yaar : | 3. Tima of Dea |
| Physician /Medical | | PETER H. | DENNING | | | | JANUARY | | | 12:03 |
| Examiner | 4 | e. Facility Neme (If not institution, give | a straat and number) | | | 4b. City, Town, or | Location of Deeth | 4c. County | | |
| | ı | 11 SILVERWOOD CIT | RCLE #11 | | | ANNAPO | LIS | ANNI | E ARUN | DEL |
| uneral | 5 | . Social Security Number 6. S | ex 7. Aç | ga (In yrs. I | Months | r 1 Yaar If Under 24 Hr Days Hours Mir | | Year) | 9. Birthplac | a (State or For |
| rector | | 190-20-9198 | X M 2□ F | 68 | Yrs. | 04,0 | SEPT. 3, | | | YLVANIA |
| > | - | Jsual Rasidance of Decedent 0a. Stata 10b. County | | 100 Cib | , Town or Location | | | | 104 | . Inside City Lir |
| aho H H H | | | | | | | | | 100. | 1)XIVes 2□ |
| Tall of | ľ | MARYLAND ANNE A | RUNDEL | 1 | ANNAPOLIS | | | 10 THE PROPERTY. | | |
| ust be notified at ust be notified at rai Director | 1 | 0a. Street end Number | | | 10f. Zi | p Code | 10 | g. Citizen of V | Vhet Country | 7 |
| 23 E | | 11 SILVERWOOD CI | | | | 21403 | | - | O STAT | |
| r tems 23 ingr must Funeral | 1 | 1. Marital Status | 12. Was Decedent Armed Forcas? | | S. 13. Was Dece | edent of Hispanic Origin? (ecify Cuben, Mexican, Pue | Specity Yes or No- into Rican, atc.) | | e - Amarican k, Whita, atc | |
| 0 1 - | | 1 Never Married 2 Married | 1X Yas 2 ☐ If Yas, Give | | 1 ☐ Yas | 2X No Specify: | | Specify | | _ |
| "natural", o rdical Expr leted by | | 3 Widowed 4 □ Divorced | Yaar or Dates: | MMTT | | | | | WHIT | |
| nt, tre Medical rt, tre Medical Completed | | 15. Decedant's Ed (Specify only highest gra | lucation de complated) | | (Giva kind of w lifa. DO NOT | ual Occupation ork dona during most of w | orking | 16b. Kind of Bu | JSIN#SS/INGUS | stry |
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| ne la la la la la la la la la la la la la | | 19a. Informant's Name/Ralationship (1 | | | _ | s (Street and Number or F | | | | |
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| AN. The law requires that the death certificate be executed within 🕶 hours after death. Page 6 may be retained by the hospital or attending physicia | uneral director, page 5 should be detached for use as the burial-to | |
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| | | 1. DECEDENT'S NAME (First, Middle, Last | | | | | 2. DATE OF OEATN | | 3. TIME OF OEATN | | |
| | | Henrietta A. Wal | lace Richards | on Davis | | | January 27 | 1996 | 18:14 | м | |
| | | 4. SOCIAL SECURITY NUMBER 326-20-5767 | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) | Coun | | 30 | |
| pino | | 9a. FACILITY NAME (If not institution, give | | THS. | OF CITY TOWAY | OR LOCATION OF DEA | December10 | | linois | _ | |
| 3 should | 8 | Memorial Hospita | , | | Cumber1 | | NIN . | Allegar | | | |
| \$ 1. 2, | 3 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | | | | | | | | = | |
| it. Page | DIRECTOR | | egany | | y, town on Locat berland | TON | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | , | |
| 020 physician. burial-transit permit. Pages 1. | FUNERAL | 100. STREET AND NUMBER 53 Cresap Street | | | 101 | 21502 | | U.S.A. | WHAT COUNTRY? | | |
| 0 E # | B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | If yes, sp | ENDENT OF NISPANI polity Cuban, Maxican 2 NO Specify: | | Blac | E — American Indian, k, White, atc. | | |
| 21215 al or attend for use as | 된 | 15. DECEDENT'S ED (Specify only highest grad | | (Give kind of | USUAL OCCUPATION | ON st of working | 16b, KIND OF BUS | SINESS/INDUSTRY | | | |
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| AND he hospit detached | once. COMPL | 17. FATNER'S NAME (First, Middle, Last) | | OTTICE | WOLKEL | 18, MOTNER'S NAM | E (First, Middle, Malden | | Doard | \dashv | |
| YL by th | 711 | John Agnew | | | | Marian | | lace | | | |
| MARYLAND retained by the hospit 5 should be detached | notified TO BE | 19a. INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Town | | | | |
| | pe n | John A. Davis | 1000 | | | | erland, Ma | | | _ | |
| 6 may be | must | 1 1 Donation \$ Other (Specify) | noval from Stata CAR | PLACE AND DATE | ther place) | | 30,1996 Ct | CATION — City or To | | 4 | |
| ALTIMOF death. Page 6 m funeral director. | | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | mse chem | 22, NAME AP | ID ADDRESS OF FAC | ILITY | | | | |
| - | examiner | Merritt-Adams Funeral Home 21502 404 Decatur Street Cumberland, Maryland | | | | | | | | | |
| the Poli | medical | 23. PART I. Enter the diseases, or | complications that caused | the death. Do r | not enter the mo | de of dying, such | aa cerdiac or reepi | ratory arreat, | Approximata | | |
| within 24 hour pletely filled in cremation, or | event, the me | IMMEDIATE CAUSE (Final disease or condition reaulting in death) | s. Due to (or as | LYNN) | ARY | ARRES | T /M. | 0.00 | Onset and D | | |
| P.O. BOX 68 th certificate be executed physician and I Hygiene prior to bur | or other traumatic | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. JULIN VERENDENT VIRETES VIELLITUS > 10 YEARS IN STEAM OF THE STAND VIRETES VIELLITUS > 10 YEARS IN STEAM OF THE STEAM O | | | | | | | | | |
| CORD; ires that the signed by the lealth and M | shows any injury, : MEDICAL CE | PART II. Other significent condition | na contributing to deeth b | ut not reaulting | in the underlying | g ceuse given in F | Pert I. 24s, WAS AN PERFOR 1 TYES 2 | MED? | AMAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? | SE | |
| > 50 | AN: N | DID TOBACCO USE CON | RIBUTE TO CAUSE O | F DEATH YE | S NO D | UNCERTAIN | | | , | | |
| 上年 皇皇 | SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | OTHER: | | | | | = | |
| F VIT. | a ≥ | 1 TYES 2 NO | 1 Inpatient 2 ER/Outp | etlent 3 DOA 285. TIM | 4 - Nursing Nom | | Other (Specify) | | | _ | |
| O F SE | marked, or BY PHY | 1 Natural 5 Pending | (Month, Day, Year) | | URY WO | RK? | 280. OESCHIBE NOW IF | NJUHY OCCUREO | | - 1 | |
| DIVISION OF VI'OR ATTENDING PHYSICIAN: ORATTENDING PHYSICIAN: DIRECTOR: After this certifica | 28 is TED | 2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide detarmined | 28e. PLACE OF INJURY building, stc. (Spec | — A1 home, farm, | street, factory, offic | 1 | 28f. LOCATION (Street a City or Town, State) | and Number or Rural | Route Number, | | |
| DI RAL OR AL DIRI | ANT: If Item 2 | | SICIAN: To the best of my know | | | | | | s) and manner as state | d. | |
| 물 물 물 | BE | 296. SIGNATURE OF CENTURE | | L N | | 294. LICENSE NUMI | | 29d, DATE SIGNED | | 1CAAV | |
| 3 | ₹ 0 | 30. NAME AND ADDRESS OF PERSON W | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type | Magnio | A MED | CTR CI | MULEUN D | WD MI | >. | |
| nas | | 31. DATE FILEJAN 27. 19 1996 | ST DEGISTIAN'S SIGN | ATURE Charles | 1 (\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \ | NA WEV |) | 1102-1101/ | 1111111111 | - | |
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| F | Dhusis | | 1. Decedent's Name (First, Middla, Last | " | | | | | 2. Date of Dea | Day | Year | 3. Time of Death | |
| | Physici /Medi | | Leonard | F. | Decke | er | | | January | 22 1 | 996 | 2:16 | an |
| | Exami | | 4a. Facility Name (If not institution, give | more Medica. | | | 2 | 4b. City, Town, or | | | | | |
| | Funeral Director | | 5. Social Security Number 6. Se 217-18-4274 Usual Residence of Decedent | x | yrs. last bii | Yrs. | er 1 Year B Days | If Under 24 Hrs Hours Min. | 8. Date of Birt (Month, Day Jul 1 | , 1922 | 9. Birthpl Count MD | lace (Stata or Forali try) | an |
| | wor. | | 10a. Stata 10b. County | 100 | . City, Tow | n or Location | | | | Padde | 10 | Od. Insida City Limit | S |
| | e Mar | ctor | MD | | Bal | timore | | | | X□Yes 2□No | | | 0 |
| | 23a or 20 | Funeral Director | 10e. Sireel and Number 2900 FreeWay | | | | ip Code 21227 | 7 | 10g. Citizen of What Country? USA | | | | |
| 010 | a within 72 hours after death with the Maryland Jiene. Then "naturel", or items 23a or 28e-f show The Mexical Expander must be notified at | by | 11. Marital Status 1 □ Navar Married ※□ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever Armed Forces? X☐ Yes 2☐ No If Yes, Giva Year or Dates: WW | | 13. Was Dec If Yes, sp | | lispanic Origin? (S an, Mexican, Puerl Specify: | pecify Yes or No- to Rican, etc.) | 14. Rac Blac Specify | | | |
| 5 | 72 hor | Completed | 15. Decedent's Edu (Specify only highest grad | cation | | Decedent's Us | ual Occup | pation during most of wo | dias | 16b. Kind of Bu | | | |
| 200-612 | 9 1 9 | npie | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | | | | c | | |
| 7 | filed with Hygiene. rither then | | 12 | | Ret | cired Wa | ırden | | | State o | | yland | |
| | should be filed and Mental Hygin marked other imatic event, in | Be | 17. Father's Name (First, Middle, Last) | | | | | | me (First, Middle, | | na) | | |
| Mal yiain | should and Men america umerica | 10 | William B. Decker 19a. Informant's Name/Ralationship (T) | | 106 | Malling Addre | ne /Straat | and Number or Ru | M. (Root | | Ctata Zin | Cada | |
| | 2 4 4 | | Betty R. Decker | pe, riiil) | | | | | | | Siate, Zip | Code) | |
| 5 | s 1 and 2 should be filed f Health and Mental Hyg itam 27 is marked other other traumatic event, | | 20a. Method of Disposition | 20 | b. Piace o | f Disposition (N | ame of | Baltimo | Date Date | 20c. Location - | City or Tox | wn, State | |
| 2 | Peges nent of I nrt: If its iry or o | | X□ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | Ramoval from Stale | | ry, crematory or lemorial | | | 01/25 | Cumberla | and I | MID | |
| Danimore, | permit. Peges 1 end Department of Health Important: If item 27 eny injury or other tr 2005. | | 21. Signature of Funeral Service Licens | | Ill | 22. Name i | and Addra | lss of Facility | al Home | Juliber 1 | ana, i | , ALD | |
| i | _ | | 23a. Part1 Enter the disease, or compi shock, or heart fallure. List only o | lications that caused he | death. Do | not anter the me | berla | | 21502 c or respiratory ar | rast. | | Approximate | |
| | Physician /Medical Examiner | | Immediate Course /Final | a. Hulti | to (or as a | an fo | | | | | | Interval Between Onset and Death | |
| | ate be executed thysician and the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enlar Underlying Cause (Disease or injury Cause and Disease or injury Cause (Disease or injury C | | | | | | | | | | | |
| x 00/00, | of Se | Physician/Medical | resulting in death) Last | Due | | uasl | | | | | | | |
| 400 | eath cer attendin I for use | lan | | V. | | | | | | | | | |
| | that the de ed by the detached | | Part II. Other significant conditions con Bulateum | | | , , | - 23 | | | obacco use co ∕ss 2□ No | | the causs of deat bebly 42 Unkno | |
| or vital necords, | aw requires is been sign 2 should be | Completed by | Belateral Renal feul | ure | | | | | 24a. Was perfo | an autopsy med? | ava | era autopsy findings allable prior to mpletion of cause death? | ì |
| Č | 0 - 0 | E O | | | | | | | 1 D Y | as 20 No | 10 | Yes 2 No | |
| 2 | iclan: The certificate rector, pag | Be | 25. Was case referred to medical examiner? | | | | | 28. Place of De | ath (Check only o | ne) | | | |
| | Physician: this certific | To | 1 Yes 2 No | · · · · · · · · · · · · · · · · · · · | 2 ER/0 | utpatient 3 🗆 [| Oth Oth | ner: 4 Nursing H | loma 5 ☐ Resid | lence 6 Oth | ar (Specify | 1) | |
| - | D 55 | | 27. Manner of Death 1 | 28a. Dala of Injury (Month, Day Yea | 28b. | Time of Injury M | 28c. Injui Wo 1 [| ryal rk? ∣Yes 2 □ No | 28d. Describe h | ow injury occur | red | | |
| DIVISION | To the Hospital or Attendii within 24 hours efter death. To the Funeral Director; A completely filled in by the fu | Certification: | 3 ☐ Suicida 6 ☐ Could not be 4 ☐ HomIcida determined | 28e. Place of Injury - building, etc. (Sp | At home, fa | arm, street, facto | ory, office | | 28f. Locallon (5 City or Tox | | er or Rura | l Route Number, | |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in | Medical | (Check only 2 Medical Exami | sicfan: To the best of my ner: On the bests of exam and mannar stated. | | d/or investigation | in, in my o | opinion, death occu | urred at the time, | date and place, | and due to | tha cause(s) | |
| | Meight Separate | Σ | 29b. Signature and title of certifier | Λ | | 2 | 9c. Licans | se nu <i>m</i> ber | | 29d. Date signe | | Day, Year) | |
| 1 | Di. | | Myshih | asmo | (Itom 20-) | (Tunn Dries) | | 5876 | | 1/22/ | 96 | | |
| , | jus | | 30. Nama and address of person who or | 4920 Ca | ample | pell B | lvd, | White | Marsh | md | 212 | 36 | |
| | Sta | ite | 31. Data filad (Month, Day, Year) | 32. Registrar's S | oignature | P 14 | | | | | | | |

g^{l. ·}

| S, P.O. BOX 6876: BALTIMORE, MARYLAND 21215-0020 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | , certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 6876 | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe | TO THE FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal. | PORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other trauma |

| | 1 - STATE REGISTRAR | STATE OF N | IARYLAND / D | | | OF | | | | YGIENE EG. NO. | | | |
|---------------|--|----------------------------|---|-----------------------------|--------------------|----------------|--------------|--------------------------|--------------------------------------|-------------------|--------------|-------------|-------------------------------------|
| 10 | 1. DECEDENT'S NAME (First, Middle, Last) | | OLI | 1111 | ICATI | _ 01 | DEAL | П | 2. DATE OF D | EATH | - | 3. TI | ME OF DEATH |
| ñ | Benjamin W | allace | | | V | URI | nA |) | MONTH | DAY | 956 | AR | 621 M |
| | | 5. SEX | 6. AGE (In yrs. last b | virthday) | IF UNDER | - Y | IF UNDER | | 7. DATE OF BI | RTH | 8. 8 | HRTHPLAC | E (State or Foreign |
| 1 7 | 217-28-3068 | 1 XM 2 🗆 F | 63 | YRS. | MONTHS | DAYS | HOURS | MIN. | July- | | | Country) | rvland |
| | 9e. FACILITY NAME (If not institution, give stre | set and number) | | | | , TOWN O | R LOCATIO | ON OF DE | | | c. COUNTY | | LYLANG |
| H H | PENINSULA REGIONA | AL MEDIC | AL CENTER | 3 | SALISBURY WICOMICO | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| 뿐 | 10a. STATE 10b. COUNTY | | | 10c. CITY, TOWN OR LOCATION | | | | LJMIT | | | INSIDE CITY | | |
| 1 -1 | Maryland Wico | <u>mico</u> | | Quantico | | | | | | | YES 2 NO | | |
| RA | | | | | 101. | ZIP CODE | | 10g. CITIZEN OF WHAT COU | | | COUNTRY? | | |
| FUNERAL | 23694 Head Of | Road TEVER IN U.S. ARMI | | 1.00 | | 218 | | | | U.S | | | |
| | 1 Never Married 2 Married | FORCES? 1 | YES 2 NO | | | If yes, spe | cify Cuba | n, Maxica | NIC ORIGIN? (Sp in, Puerto Rican, | etc.) | | Black, Whi | mericen Indian, ia, etc. |
| B | 3 Widowed 4 Divorced | Korear | | | | 1 TES | 2 NO | Specif | у: | | | Specify: | Lack |
| 유 | 15. DECEDENT'S EDUCA | ATION | 10a, DECE | DENT'S | USUAL O | CCUPATIO | N . | | 16b. KINI | OF BUSINE | SS/INDUST | | Lack |
| Ш | (Specify only highest grade of Elementary/Secondary (8-12) | College (1-4 or 5 - | (Give | o NOT u | se retired.) | during mos | st of workin | 9 | | | | | |
| MP. | 12 | | Lal | oor | er | | | | | None | 0 | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | HER'S NA | ME (First, Middle | , Maiden Sun | name) | | |
| BE (| Benjamin Frank | lin Dor | cman | | | | Ma | ry | Emma I | rice | | | |
| 01 | 19a, INFORMANT'S NAME (Type/Print) | | 100 | | | | | | Route Number, C | | | | |
| - | Peggy Smith | | | | | | | d.A | pt.H,I | | | | 21206 |
| | 20a, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove | val from State | 20b. PLACE AN | atory or o | ther place | | me of | | DATE 2/3 | 20c. LOCAT | | | |
| | 4 Donation 5 Other (Specify) | | Head | 0f | Cre | eek_ | | | | Qua | ntic | 10, M | 1. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | _ | | NAME AN | | | eral H | lome | | | |
| | Bladys t | 3, 27 | wart | | | | | | .Salis | | , Md. | 2180 |)1 |
| | 23. PART I. Enter the diseases, or co | emplications the | t ceueed the deer | lh. Do | not enter | the mo | de of dyl | ing, suc | h ee cerdiec | or respirate | ory arrest, | | Approximete Interval Between |
| | IMMEDIATE CAUSE (Fine) | let only one cat | A A | 6 | 2 | | 7, | | | | | | Onset and Death |
| | disease or condition resulting in death) | | (Calo | 12 | inc | San l | liles | | | | | | |
| | 2.5 | DUE 10 | (OR AS A CONSEQU | HENCE O | P. | | 2 | | _ | | | | |
| N N | Sequentially list conditions, | | Rule | ap | Seco: | sell, | rose | 5 | | | | | |
| F | If any, leading to immediate cause. Enter UNDERLYING | DUE TO | (OR AS A CONSEOU | IENCE O | F): | | | | | | | | |
| 5 | CAUSE (Disease or Injury \$ c. | DUE TO | (OR AS A CONSEQU | IENCE O | ifi: | | | | | | | - | |
| E | that initiated eventa reaulting in death) LAST | | (01111011010101010101010101010101010101 | | . ,. | | | | | | | Ì | |
| CERTIFICATION | d | | | | | | | - No. 10 | | | | | |
| CAL | PART II. Other significent conditions | contributing to | death but not re- | eulting | in the u | nderiying | cause | given in | Part i. 24a | . WAS AN AUT | | | E AUTOPSY FINDINGS ABLE PRIOR TO |
| - | CARCHE | c /6 | nul to | sel | eu i | 20 6 | hra | · X2 | Kely | YES 2 | | COM | PLETION OF CAUSE EATH? |
| MED | Covon | ary (| litery (| 12: | 3000 | 1 | | | | | | | YES 2 NO |
| | DID TOBACCO USE CONTR | IBUTE TO CA | USE OF DEAT | HY | ES 🗆 | NO [| UNC | ERTAI | N 🗆 | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 28. PLACE | OF DEA | - | | | | | | | | |
| SI | 1 YES 2 NO | 1 Impetient 2 | ER/Outpatient 3 | DOA | OTHE 4 - Nu | | e 5 □ Re | sidence | 8 Other (Spi | ecify) | | | |
| PHY | 27. MANNER OF DEATH | 28a. DATE OF (Month, D | | 28b. TIR | JURY | 28c. INJ WO | URY AT | | 28d. DESCRIE | BE HOW INJU | RY OCCUR | ED | |
| à l | 1 Natural 5 Pending 2 Accident Investigation | | | | М | 1 🗆 1 | | NO | | | | | |
| 8 | 3 Suicide e Could not be | 28a. PLACE C building. | of INJURY — At hom atc. (Specify) | a, farm, | atroot, fac | tory, office | | | 28f. LOCATION City or Tox | | Number or F | Rural Route | Number, |
| | | | | | | | | | | : | | | |
| 교 | (Check only 1 CERTIFYING PHYSIC | | | | | | | | | | | | |
| COMPLET | one) 2 MEDICAL EXAMINER | t: On the besis of a | xemination and/or in | veatigati | on, In my | opinion, d | eath occu | red at the | time, data and | place, and d | us to the ca | euse(a) and | manner as stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 1 | 01 | | | | 29c. LIC | ENSE NU | MBER | 21 | Pd. DATE SP | GNED Mon | th, Daf. Year) |
| TO B | Pento | J. | (nan) | | | | D | -20 | 3050 | | 1 | 1291 | 196 |
| = | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAU | SE OF DEATH (ITEM | 27) (Typ | e, Print) | 0 | 0 | | 10 | | , / | / | |
| | BENI 10 | 9.61 | THU | S | 77- | 01 | Kiv. | ensi | de de | V. | ablah | 3/ | 1021801 |
| | 31. DATE FILED (Month, Day, Year) | | AB'S SIGNATURE | 1.11 | | | | | | | / | | |

pital or attending physician. and to use as the burlal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| ter death. Page 6 may be retained by the hosp | e funeral director, page 5 should be detached. | examiner must be notified at once. | |
|---|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detaiche be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| TO THE HOSPITAL OR ATTENDING PHY. | TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with | IMPORTANT: If item 28 is marked | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

8

| 1 - FOR STATE REGISTRAR | SIAIL OF MANIL | AND / DEPARTI CERTIFIC | | | REG. NO. | E | | |
|--|--|--|--|--|--|---|--|----------------------------|
| 1. DECEDENT'S HAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF D | EATH |
| MYRTLE RA | AYNE D | ENNIS | | | January 29. | | EAR 91K |) A.M |
| 4. SOCIAL SECURITY HUMBER | 5. SEX 6. AGE (/ | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 6. | BIRTHPLACE (State o | |
| 219-07-4221 | □ M 2 🔀 F 94 | YRS. | ONTHS DAYS | HOURS MIN. | (Month, Day, Year) November 16, | | Maryland | |
| 9a. FACILITY NAME (If not institution, give alre- | ef and number) | 9 | b. CITY, TOWN (| OR LOCATION OF DEAT | | 9c. COUNTY | | |
| ATLANTIC GENERAL | L HOSPITAL | 1 | BERL: | ĹN | | WO | RCESTER | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE 10b. COUNTY | | | TOWN OR LOCAT | | | | 19d. INSIDE C | ITY |
| | comico | Pow | ellvil: | | | | 1 1 YES 2 | □ NO |
| 10e. STREET AND HUMBER | | | 101 | . ZIP CODE | | | OF WHAT COUNTRY | 7 |
| Mt. Hermon Rd. | | | | 21852 | | US | Α | |
| 11. MARITAL STATUS 1 Never Married 2 Married | 2. WAS DECEDENT EVER IN FORCES? 1 YES | | | ENDENT OF HISPANIC solfy Cuban, Maxican, | ORIGIN? (Specify Yes Puerto Rican, etc.) | or No- 14. | . RACE — American In Black, White, atc. | ndian, |
| 3 🔀 Widowed 4 🗌 Divorced | IF YES, GIVE WAR OR DA | TES | | 2X NO Specify | | | Specify: | |
| 15. DECEDENT'S EDUCA | TION I | 16a. DECEDENT'S US | 1 | | | | White | |
| (Specify only highest grade co | mpleted) | (Give kind of work life. Do NOT use n | k done during mo | | 16b. KIND OF BUS | INESS/INDUS | TRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Homen | | | Domes | atio | | |
| 17. FATHER'S NAME (First, Middle, Lest) | | nomen | laker | Tra marine in the | | | | |
| | D | | | | (First, Middle, Maiden | , | | |
| Henry 19a. INFORMANT'S NAME (Type/Print) | Rayne | | | Ella | | unknow | | |
| | | | | | O | | | |
| Elizabeth Trader | | | | | Stockton | | | |
| 20a. METHOD OF DISPOSITION t X Burlat 2 Cremation 3 Remove | at from State come | PLACE AND DATE OF I | DISPOSITION (Na place) | me of | DATE 20c. LOC | CATION — City | or Town, State | |
| 4 Donation 6 Other (Specify) | Internal Control | Powellvil | | | 1/31 Por | wellvi | lle, MD | |
| The state of the service Licer | 100 | | | io address of facil Loway Fund | | | | |
| 1 | Oltova | _ | | | 1 Rd., Sa | lichur | y,MD 2180 | 1 |
| 23. AHT I/Enter the diseeses, or con | nplications that caused | the deeth. Do not | enter the mo | de of dying such a | an complete or month | rion o | Approx | |
| shock, or haert fallure. Lie | | | | ao or aying, sacir i | as ceruled of reepil | atory arrest | 'i ubbiox | 1111010 |
| IMMEDIATE CAUSE /Final | of only one of the off pe | ich lina. | | ao or aying, agon i | as ceruiec or reapi | atory arrest | interval | Batween |
| iMMEDIATE CAUSE (Final disease or condition | Strain of the original original original original original original original original original original origin | 0.4 | - 1 | | as cerdied of reepi | atory arrest | interval | |
| | Reno | J | Eaila | re | | | Onset i | Batween and Death |
| disease or condition | Reno | J | Eaila | re | | | Onset i | Batween and Death |
| disease or condition resulting in death) e. Sequentially list conditions, b. | Reno | consequence of: | Eaila | re | + F | | Onset i | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | consequence of: | Eaila | re | | | Onset i | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | consequence of: | Eaila | re | | | Onset i | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A | CONSEQUENCE OF): | Eaila | re | | | Onset i | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): CONSEQUENCE OF): | Eailu 2 1 | re 4eart | L 1-0 | ni/vi | interval Onset i 10 | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): CONSEQUENCE OF): | Eailu 2 1 | re 4eart | L 1-0 | AUTOPSY | Onset i | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): CONSEQUENCE OF): | Eailu 2 1 | re 4eart | A | AUTOPSY MED? | interval Onset a // / / / / / / / / / / / / / / / / / | PENDINGS OR TO |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other eignificent conditions | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): | the underlying | re 4eart | ATT I. 24e. WAS AN PERFORM | AUTOPSY MED? | interval Onset a // / / / / / / / / / / / / / / / / / | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): CONSEQUENCE OF): t not resulting in | the underlying | re 4eart | art I. 24a. WAS AN PERFORE 1 YES 2 | AUTOPSY MED? | 24b. WERE AUTOPS ANALABLE PRICOMETION DF DEATH? | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other eignificent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL | DUE TO (OR AS A DUE TO (OR AS A Contributing to death but | CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the second of the second o | the underlying | 4 Cart | art I. 24a. WAS AN PERFORE 1 YES 2 | AUTOPSY MED? | 24b. WERE AUTOPS ANALABLE PRICOMETION DF DEATH? | Batween and Death |
| Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other eignificent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in F DEATH YES 28. PLACE OF DEATH | the underlying NQ Check only one) | 4 Cart | PERFOR | AUTOPSY MED? | 24b. WERE AUTOPS ANALABLE PRICOMETION DF DEATH? | Batween and Death |
| Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MAHHER OF DEATH | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death be BUTE TO CAUSE O | CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in F DEATH YES 28. PLACE OF DEATH | the underlying (Check only one) THER: Hursing Hom F 28c. (NJ | G CSUSE GIVEN IN PA | PERFOR | AUTOPSY MED? PNO | interval Onset is // / / / / / / / / / / / / / / / / / | Batween and Death |
| Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initisted eventa resulting in deeth) LAST PART II. Other eignificent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANHER OF DEATH Hetural 5 Pending | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death but BUTE TO CAUSE O | CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequence | the underlying (Check only one) THER: Hursing Hom F 28c. (NJ | G cause given in Pa UNCERTAIN 5 G Rasidenca 6 URY AT 2 | art I. 24a. WAS AN. PERFOR 1 YES 2 | AUTOPSY MED? PNO | interval Onset is // / / / / / / / / / / / / / / / / / | Batween and Death |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1. Heturni 5 Pending Investigation 3 Suicide 6 Could not be | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF 10 SPITAL: Inpellant 2 ER/Output 28a. DATE OF INJURY (Month, Day, Year) | CONSEQUENCE OF): CONSEQUENCE | the underlying Check only one) THER: Hursing Hom W M 1 | Course given in Pa Y UNCERTAIN 5 Residence 6 UNY AT 2 ES 2 NO | Other (Specify) Other (Specify) Bd. DESCRIBE HOW IN | AUTOPSY MED? NO | 24b. WERE AUTOPS: AMAILABLE PRI COMPLETION D DF DEATH? 1 YES 2 | Batween and Death |
| Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initisted eventa resulting in deeth) LAST PART II. Other eignificent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANHER OF DEATH 1 Hetural 5 Pending Investigation | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A CONTributing to death but BUTE TO CAUSE OF 10 SPITAL: Inpellent 2 ER/Output 26a. DATE OF INJURY (Month, Day, Year) | CONSEQUENCE OF): CONSEQUENCE | the underlying Check only one) THER: Hursing Hom W M 1 | Course given in Pa Y UNCERTAIN 5 Residence 6 UNY AT 2 ES 2 NO | art I. 24s. WAS AN PERFORM 1 YES 2 Other (Specify) 16d. DESCRIBE HOW IN | AUTOPSY MED? NO | 24b. WERE AUTOPS: AMAILABLE PRI COMPLETION D DF DEATH? 1 YES 2 | Batween and Death |
| Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MAHHER OF DEATH Hetural 5 Pending Investigation 3 Suicide 6 Could not be detarmined | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF 10 SPITAL: Inpellant 2 ER/Outpel 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Special | CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequenc | the underlying NO | Court of Cou | Other (Specify) Other (Specify) Other (Specify) Red. DESCRIBE HOW IN City or Town, State) | AUTOPSY MED? NO NJURY OCCUR | 24b. WERE AUTOPS: AMAILABLE PRI COMPLETION D DF DEATH? 1 YES 2 | Batween and Death |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MAHHER OF DEATH Hetural 5 Pending Investigation | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF 10 SPITAL: Inpellant 2 ER/Outpel 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Special Contribution) | CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequenc | the underlying NO | Course given in Pa UNCERTAIN Solution of the service of the serv | art I. 24a. WAS AN. PERFORE 1 YES 2 Other (Specify) 88. LOCATION (Street a City or Town, State) | AUTOPSY MED? NO NJURY OCCUR | interval Onset is // // // // // // // // // // // // / | FINDINGS OR TO SECULAR NO |
| Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MAHHER OF DEATH Hetural 5 Pending Investigation 3 Suleide 6 Could not be defarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF 10 SPITAL: Inpellant 2 ER/Outpel 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Special Contribution) | CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequenc | the underlying NO | Course given in Pa Y UNCERTAIN To S Rasidenca 6 URY AT RK7 YES 2 NO and place, and due to eath occured at the time | Other (Specify) Other (Specify) Other (Specify) Red. DESCRIBE HOW IN Other (Specify) The Cause (a) and manner, data and place, and | AUTOPSY MEO? NO NJURY OCCUR not Number or in | 24b. WERE AUTOPS: AMAILABLE PRI COMPLETION D DF DEATH? 1 YES 2 | FINDINGS OR TO FE CAUSE NO |
| Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF 10 SPITAL: Inpellant 2 ER/Outpel 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Special Contribution) | CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequenc | the underlying NO | Course given in Pa UNCERTAIN Solution of the service of the serv | Other (Specify) Other (Specify) Other (Specify) Red. DESCRIBE HOW IN Other (Specify) The Cause (a) and manner, data and place, and | AUTOPSY MEO? NO NJURY OCCUR not Number or in | interval Onset is // // // // // // // // // // // // / | FINDINGS OR TO FE CAUSE NO |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initisted eventa resulting in death) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANHER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29a. CETHIFIER Chack only One) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER | DUE TO (OR AS A DUE TO | CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequence | the underlying (Check only one) THER: Hursing Hom OF 28c. (NJ) Y M 1 1 1 vet, factory, officiant the time, data In my opinion, d | Course given in Pa UNCERTAIN Solution of the state of t | art I. 24a. WAS AN. PERFORE 1 YES 2 Other (Specify) 18d. DESCRIBE HOW IN 18t. LOCATION (Street a City or Town, State) the cause(a) and manne, data and place, and | AUTOPSY MEO? NO NJURY OCCUR not Number or in | 24b. WERE AUTOPS: AMAILABLE PRI COMPLETION D DF DEATH? 1 YES 2 | FINDINGS OR TO FE CAUSE NO |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other eignificent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR AS A DUE TO | CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequence | the underlying (Check only one) THER: Hursing Hom OF 28c. (NJ) Y M 1 1 1 vet, factory, officiant the time, data In my opinion, d | Course given in Pa UNCERTAIN Solution of the state of t | art I. 24a. WAS AN. PERFORE 1 YES 2 Other (Specify) 18d. DESCRIBE HOW IN 18t. LOCATION (Street a City or Town, State) the cause(a) and manne, data and place, and | AUTOPSY MEO? NO NJURY OCCUR not Number or in | 24b. WERE AUTOPS: AMAILABLE PRI COMPLETION D DF DEATH? 1 YES 2 | FINDINGS OR TO FE CAUSE NO |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initisted eventa resulting in death) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANHER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29a. CETHIFIER Chack only One) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER | DUE TO (OR AS A DUE TO | CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): At not resulting in the consequence of the consequence | the underlying (Check only one) THER: Hursing Hom OF 28c. (NJ) Y M 1 1 1 vet, factory, officiant the time, data In my opinion, d | Course given in Pa UNCERTAIN Solution of the state of t | Other (Specify) | AUTOPSY MEO? NO NJURY OCCUR not Number or in | 24b. WERE AUTOPS: AMAILABLE PRI COMPLETION D DF DEATH? 1 YES 2 | FINDINGS OR TO FE CAUSE NO |

BALTIMORE, MARYLAND 21215-0020

executed within OR ATTENDING PHYSICIAN: The law requires

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Pages 1, 2, 3 should permit. for use as the burial-transit Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-tran once. to notified eq. must funeral director, medical examiner hours after death. the attending physician and completely filled in by the I Mental Hygiene prior to burial, cremation, or removal. the event, traumatic or other signed by the shows any has been s Dept. of H 23 certificate to the State the . this ca marked, After t 28 Is DIRECTOR: A item TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 h

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 1996 YEAR DAY Jan 26, 1900 hrs. M MARY JANE DAVIS 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MONTHS DAYS 1 🗆 M 2 😿 F HOURS YRS. Jan 18, 1921 West Virginia 75 232-56-7767 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Worcester Atlantic General Hosp. Berlin RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Wicomico Parsonsburg 1 YES 2X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7125 Wainwright Ave. U.S.A. 21849 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, stc.)

1 YES 2 NO Specify: 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES BY 3XX Widowed 4 XX Divorced Specify: White ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY E Elementary/Seco ndary (0-12) College (1-4 or 5+) COMPL Licensed Pract, Nurse Medicine 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Daniel O'Neal Martha J. Mitchum BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ACORESS (Street and Number or Bural Boute Number City or Trees, State, Zio Code) 2 Helen Beeman 7125 Wainwright Ave., Parsonsburg, Md. 21849 20a. METHOD OF DISPOSITION
1 A Buriet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) Springhill 129 Memory Gdns. Hebron, Md. 22. NAME AND ADDRESS OF FACILITY Bounds Funeral Home, Salisbury
23. Pant 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Bounds Funeral Home, Salisbury, Md.21801 shock, or heart fellura-List only one cause on each line. interval Retween IMMEDIATE CAUSE (Finei Onset and Death disease or condition unkn DUE TO(JOR AS A CONSEQUENCE OF): resulting in death) 12/25 oue to (or as a consequence of): CERTIFICATION Sequentisity ilst conditions, if sny, lesding to immediate 000 cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 - NO itlent 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF OFATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner es stated. 29b. DESKANURE AND TOLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

1 26/96 8 H43617 Tou ueen 9 ME AND ADD HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Berlin 21811 112 20 Branch

32. REGISTRAR'S SIGNATURE

In Davilson Randall

31. DATE FILEO (Month, Day, Year)

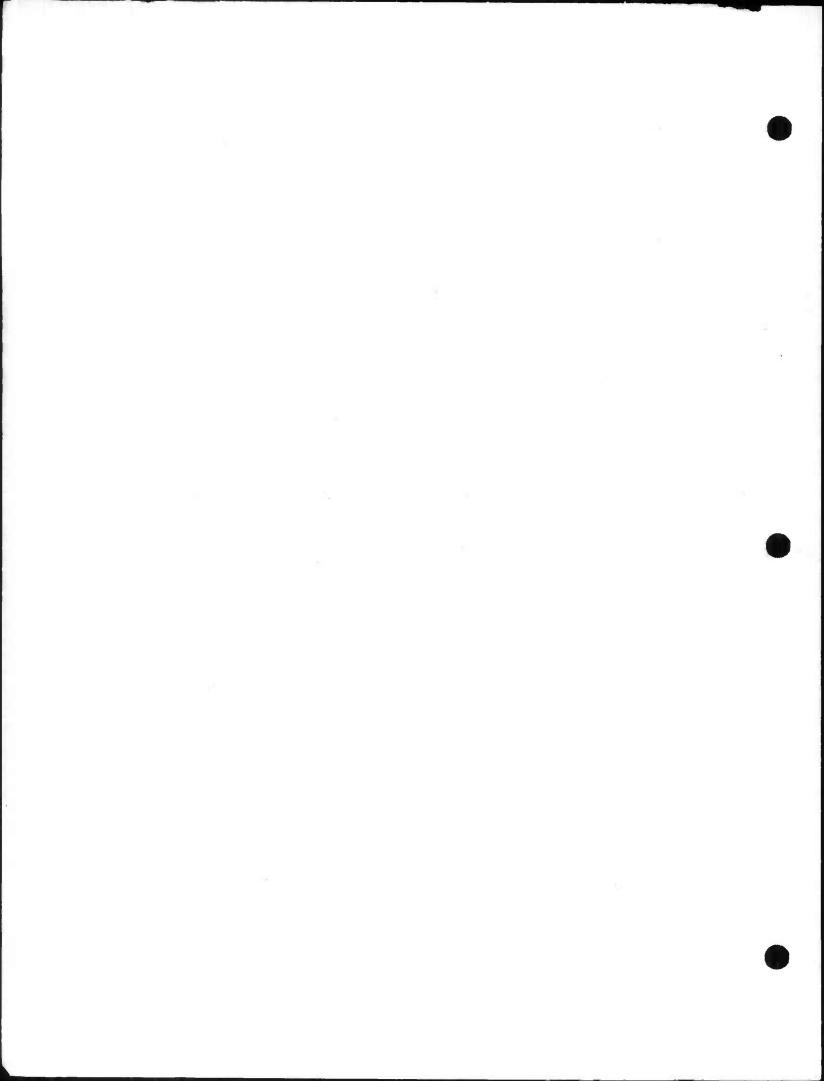
2 9 1996

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | 10 | after death with the State Dept. of Health and Mental Hygiene prior to burkal, cremation, or removal. | 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|---|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN | TO THE FUNERAL DIRECTOR: After this certific | be filed within 72 hours after death with the S | IMPORTANT: If item 28 is marked, or i |

| | 1 - STATE OF MARYLA | | MENT OF H | | MENTAL HYGIEN | | | | | | |
|------------------|---|--|---|--------------------------------|---|-----------------------------------|---|--|--|--|--|
| | t. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | 3. TIME OF OEATH | | | | | |
| | Jose Luis /)[0 | 12 | | | 1 2-7 | 96 YEA | " 1153p M | | | | |
| | | At a Control of the C | | | | | | | | | |
| DIRECTOR | None 1 M 2 T F 98. FACILITY NAME (If not institution, give street and number) | YRS. | | ONTHS DAYS HOURS MIN. Jan. 27, | | | 1996 Maryland | | | | |
| | Holy Cross Hospital | omery | | | | | | | | | |
| | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 10d. INSIDE CITY | | | | | | | | | |
| <u>E</u> | Maryland Montgomery | | town on Locati | | | LIMITS? | | | | | |
| | 10e. STREET AND NUMBER | Gaithersburg | | | | 10g. CITIZEN C | OF WHAT COUNTRY? | | | | |
| FUNERAL | 947 Clopper Road, #B-4 | | | | Unit | ed States | | | | | |
| 5 | 1t. MARITAL STATUS t2. WAS DECEDENT EVER IN | | | | IC ORIGIN? (Specify Ye | s or No.— 14. F | IACE — American Indian, Black, White, atc. | | | | |
| BY F | 1 M Never Married 2 Married FORCES? 1 YES 3 Widowed 4 Divorced FYES, GIVE WAR OR DA | | | | | | Specify: | | | | |
| - 1 | 15. OECEDENT'S EDUCATION | White | | | | | | | | | |
| ETE | (Specify only highest grade completed) | (Give kind of wo | in. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 3 | Elementary/Secondary (0-12) College (1-4 or 5+) | No | None | | | None | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 16. MOTHER'S NAM | ME (First, Middle, Malden | | | | | | |
| BE (| Jose Luis Diaz | | | Cira | | | | | | | |
| 0 | 1Se. INFORMANT'S NAME (Type/Print) | 19b. MAILING A | | | loute Number, City or Tox | rn, State, Zip Code |) | | | | |
| | Jose & Cira Diaz | | Same as | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burlai 2/(YCremation 3 Ramoval trom State 4 Donation 3 Other (Specify) Chesapeake Crematory 1-30 Beltsville. Marylan | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | · Ellen XI. Kap | | | | | | Services, P. A. nue, Silver Spring, MD 20910 | | | | |
| | 23. PART I. Enter the diseases, or complications that caused | the death. Do no | | | | | Approximate | | | | |
| | ahock, or heart fallura. List only one cause on each line. IMMEDIATE CAUSE (Finel Onset and Death | | | | | | | | | | |
| | disease or condition reaulting in death) a. Extreme prematurity DUE TO (OR AS A CONSEQUENCE OF): 10 min. | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| No. | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| S | CAUSE (Disease or Injury | | | | | | | | | | |
| | that initiated evants reaulting in death) LAST | | | | | | | | | | |
| CERTIFICATION | d | | | | | | | | | | |
| AL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO | | | | | | | | | | |
| PHYSICIAN: MEDIC | 1 Yes 2 No | | | | | | | | | | |
| ME | | | | , | | | t 🗆 YES 2 NO | | | | |
| AN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐ | | | | | | | | | | |
| Sic | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | |
| HYS | 1 Pes 2 NO 1 Inpettent 2 ER/Outpattent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED | | | | | | | | | | |
| ВУ Р | 1 X Natural 5 Pending (Month, Day, Year) | INJU | INJURY WORK? M 1 YES 2 NO | | | 255. GESSINGE HOW MASKIT GESSINES | | | | | |
| | 3 Suicide 6 Could not be 26s. PLACE OF INJURY building, stc. (Speci | | reet, factory, office | | 261. LOCATION (Street and Number or Rural Route Number, | | | | | | |
| COMPLETED | 4 Homicide determined building, stc. (Specify) City or Town, State) | | | | | | | | | | |
| 1 | 29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated. | | | | | | | | | | |
| S | one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated, | | | | | | | | | | |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (MORITI, Day, Year) 1/28/96 | | | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED PAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | |
| | JOAN M. KELLY M.D. 1500 FOREST GLEN RD SILVER SPRING MD 20910 | | | | | | | | | | |
| | JAN 30 1996 Juli Davels | Charlette | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Land

| | | | | State of | Maryland | | artment of I | Health and Death | | giene 9 | 6 | 036 | 96 | |
|-------------|--|----------------|---|--|------------------------------------|-----------------------|---|---|---------------------------------|----------------------------------|-------------|---|-------------|--|
| | | | 1. Decedent's Name (First, Midd | | | | | 2. Date of Dea Month | th | W | 3. Time | of Death | | |
| | Physici /Medic | | T | | | Daugharthy | | | | 30, 19 | Year 196 | 8:45 | pm | |
| > | Examir | | 4a. Facility Name (If not institution | n, give street end numb | er) | | | 4b. City, Town, or | Location of Death | 4c. County | y of Death | | | |
| | | | Washington Adve | | | | | Takoma P | ark | Montg | | | | |
| | Funeral | | 5. Sociel Security Number | 6. Sex 7. | Age (In yrs. las | | If Under 1 Year Months Deys | If Under 24 Hrs Hours Min. | | r, Year) | 9. Birth | place (State | or Foreign | |
| | Director | | 198-16-5961 Usuel Residence of Decedent | | 90 | Yrs. | | | July 24 | ,1905 | | sylva | | |
| | land m | tor | 10a. State 10b. County | | 10c. City, T | Town or Lo | cation | | | | | 10d. Inside | City Limits | |
| | Mary | | Maryland Prince | George's | Takom | n Dar | ·1· | | | | | 1 [A] Ye | s 2 No | |
| | 1 the | Director | 10e. Street and Number | c deorge s | Takom | a lai | 10f. Zlp Code | | | log. Citizen of | What Cou | intry? | | |
| | h with | | 7614 Glenside (| Court | | | 20912 |) | | T | J.S.A | | | |
| | dead | Funeral | 11. Meritel Stetus | 12. Was Decede Armed Force | nt Ever in U,S. | 13. | | Hispanic Orlgin? (S en, Mexican, Puerl | pecify Yes or No- | | | ican Indien, | | |
| 0 | or its | | 1 Never Merried 2 Men | ried 1 Yes 2 | | | 1 □ Yes 2 ☒ No | | o ricali, etc.) | Specia | | , etc. | | |
| Š | filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or ferms 23a or 28a-f show ent, the Medical Examinet must be noutled at | Completed by | 3 ☑ Widowed 4 □ Divorced | Year or Date | | | | | | | | White | | |
| 21215-0020 | neth | | 15. Deceden (Specify only highe | t's Education st grade completed) | 1 | (Give | dent's Usuel Occu kind of work done DO NOT use retire | during most of wo. | rking | 16b. Kind of E | lusiness/li | ndustry | | |
| 12 | withii | d L | Elementary/Secondary (0-12) | College (1-4 | | | Employed | 0) | 10 | roporti | . Man | 00000 | nt | |
| 0 | filed Hygi | To Be Co | 17. Father's Name (First, Middle, | Last) | | ell i | Emproyea | 18. Mother's Na | me (First, Middle, | roperty Maiden Sumai | | lageme | пс | |
| 8 | Mental Mental arked o | | Elson Daughar | thv | | | | Julia | Adams | | | | | |
| Maryland | S D E E | | 19a. Informent's Neme/Relations | | | 19b. Maillr | ng Address (Street | end Number or Ri | | r, City or Town | , State, Z | ip Code) | | |
| | and 2 saith a n 27 is | | Julia Ann Benne | ett | | 7614 | Glenside | Court | Takoma P | ark. Ma | rvla | nd 20' | 912 | |
| altimore, | of He | | 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation | 2 Pamoual from Sta | 0.00 | e of Dispo | sition (Name of matory or other pla | | 2/2/96 | 20c. Location | | | | |
| E | Peges ment of ant: If its ury or o | | 4 Donation 5 Other (S | | Mt. Z | Zion l | United Me | ethodist | | ighlan | d, Ma | rylan | .d | |
| Ball | permit. Peges 1 and 2 Department of Health a Important: if item 27 is any injury or other trat once. | | 21. Signature of Funeral Service Upensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. | | | | | | | | | | | |
| | 00500 | | Mobert. | Z. Nan | 2364 | | | sity Blv | | | | 20901 | | |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that cau- only one cause on eec | sed the death. I h line. | Do not ent | er the mode of dyi | ng, such es cardie | or respiratory and | rest, | 1 | Approxim Interval B | etween | |
| b | Physician /Medical | | Onset end Death | | | | | | | | | | | |
| | Examiner | | disease or condition resulting in death) | a Aspira | | | | | | | | | | |
| | ACCESSES. | Examiner | | | Due to (or as | | | 0 | | | į | | | |
| | be executed sicien and buriel-transit | | Sequentially list conditions. Congestive Heart Failure 2° to ASHD Due to (or as a consequence of): | | | | | | | | | | | |
| ,09 | be executed icien and buriel-transit | | | | | | | | | | | | | |
| | 0 2 0 | Jicai | that initiated events Due to (or es e consequence of): | | | | | | | | | | | |
| × | requires that the death certificat seen signed by the ettending phy should be detached for use es th | Physician/Med | | | | | | | | | | | | |
| Rox | ath c | | | | | | | | | | | | | |
| o. | y the check | ysi | Part II. Other significant condition | ona contributing to deat | n but not resultir | ng in the u | nderlying cause gi | ven in Part I. | | obacco use co | | | | |
| 7 | v requires that the de been signed by the s should be detached | by Pt | | | | | | | 101 | 1 Yee 2 No 3 Probably 4 Unknown | | | | |
| Hecords, | quires n sign | d b | | | | | | | 24a. Wes | an autopsy | | Vere autops | | |
| ပ္သ | | Completed | | | | | - S | | perfor | med? | C | vailable prio ompletion of f death? | cause | |
| | 0 - 0 | omp | | | | | | | 1 🗆 Y | es 2XINo | 1 | ☐ Yes 2 | □No | |
| Vital | dcian: The certificate rector, pag | Be C | 25. Was case referred to medica | | | | | 26. Place of De | eth (Check only or | | | | | |
| | Physician: r this certific rral director, | To | examiner? 1 Tes 2 No | Hospital: | atient 2 ER | /Outpatien | t 3 DOA Ott | her: 4 🗆 Nursing H | lome 5 Resid | ence 6 Ott | ner (Spec | ify) | | |
| | De le le le le le le le le le le le le le | | 27. Manner of Death 1 XNatural 5 ☐ Pendir | 28e. Date of I (Month, | njury 28 Da <i>y Year)</i> | Bb. Time of Injury | 28c. Inju Wo | ry at rk? | 28d. Describe h | ow Injury occu | rred | | | |
| 200 | Attending or death. | cati | 2 Accident investig | gation not be | | | | Yes 2 No | | | | | | |
| DIVISION OF | X # = C | Certification: | 4 Homicide determine | ined 286. Placa of | Injury - At home etc. (Specify) | e, farm, str | eet, factory, offica | | 28f. Location (S City or Tow | | ber or Ru | ral Route Nu | ımber, | |
| _ | pital ours eral filled | | 29a. Certifier 12 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. | | | | | | | | | | | |
| | To the Hospital or within 24 hours efter To the Funeral Director completely filled in | edicai | 29a. Certifier 1 Certifyin (Check only one) | g Physician: 10 the be Examiner: On the basis and manner | s of examination | and/or inv | vestigation, in my | opinion, deeth occu | rred at the time, o | ause(s) end m lete and placa, | and due | to the cause | e(s) | |
| | vithin ro the | Me | 29b. Signature and title of certifie | - 1 | / | | 29c. Licens | se number | 2 | 9d. Date signe | ed (Month | , Day, Year) |) | |
| | - > - 0 | | A 8% | Sult | 2 |) | D2190 | n | Te | nuary | 31. | 1996 | | |
| | | | 30. Neme end eddress of person | who completed cause of | of death (item 23 | Ba) (Type, | | | pe | -IIGUL y | J., . | | | |
| | | | Smith S. Ho, M. | | Carroll | | ,#280 | Takoma Pa | ark, MD | 20912 | | | | |
| | Sta | - | 31. Date filed (Month, Day, Year) | 32. Regi | Strar's Signature | P . | | | | | | | | |
| | Registr | | FEB 01 | 1996 July | dimensi | rada | | | | | | | | |
| UHI | MH 16 Rsv 6/9! |) | • | | | | | | | | | | | |

Registrar

REG. NO

DAY

2. DATE OF DEATH

JAN

7. DATE OF BIRTH
(Morth, Day, Year)
June 30,1928 67 1 M 2 X F 005 24 3625 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Holy Cross Hospital Silver Spring RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Rockville 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE be detached for use as the burial-transit 4706 Red Fox Road 20852 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc." 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 12 Administrative Assistant | U.S. Government once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) te George Mullen BE Emma Moulin funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Judith D. Lun 12510 Spring Harbor Place, Germantown, MD 20874 Page 6 may be 9 20b. PLACE AND DATE OF DISPOSITION (Name of 2008) 200. 1996 cometery, crematory or other place) 200. 1996 Montgomery Crematorium, Inc. 20a, METHOD OF DISPOSITION
1 □ Burlel 2 ※ Cremetion 3 □ Rem 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Bethesda, Maryland 21. BIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery examiner death. Home/Rockville, Inc. Avenue, Rockville, Maryland 203

Since the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. M00689 completely filled in by the Avenue, Rockville, Maryland 20850-2805 yours after medical IMMEDIATE CAUSE (Final # disease or condition_ RESPIRATORY DISTRESS SYDROME ACUTE event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) bortal. FAT EMBOLISM fraumatic CERTIFICATION put Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiera prior to requires that the death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the any 1 YES 2 NO has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\mathbb{Z}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL: OTHER 1 YES 2 R NO ATTENDING PHYSICIAN: 1 K Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 5 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED with w 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 3 Suicide 291. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 6 Could not be determined DIRECTOR: / COMPLETED 4 Homicide 28 DR 29a. CERTIFIER 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL I within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the bi tion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITUE OF CERTIFIER 29c. LICENSE NUMBER BE 10 CON lei 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12201 PLYM ORCHARD DR. VICTOR STEIG COLESVILLE MD 20910

Julia Davidson-Rardall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

UNDER 1 YEAR

IF UNDER 24 HRS.

6. AGE (In yrs. lest birthe

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

4. SOCIAL SECURITY NUMBER

31. DATE FILED (Month, Day, Year)

JAN

31 1996

ene.

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

SpecMy: White

1 YES 2 K NO

Approximata

Onset and Death

Zweeks

Zweeks.

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO

COMPLETION OF CAUSE

1 TYES 2 NO

29d. DATE SUCNED (Marrie Day, Year)

8. BIRTHPLACE (State or Foreign

Maine

Montgomery

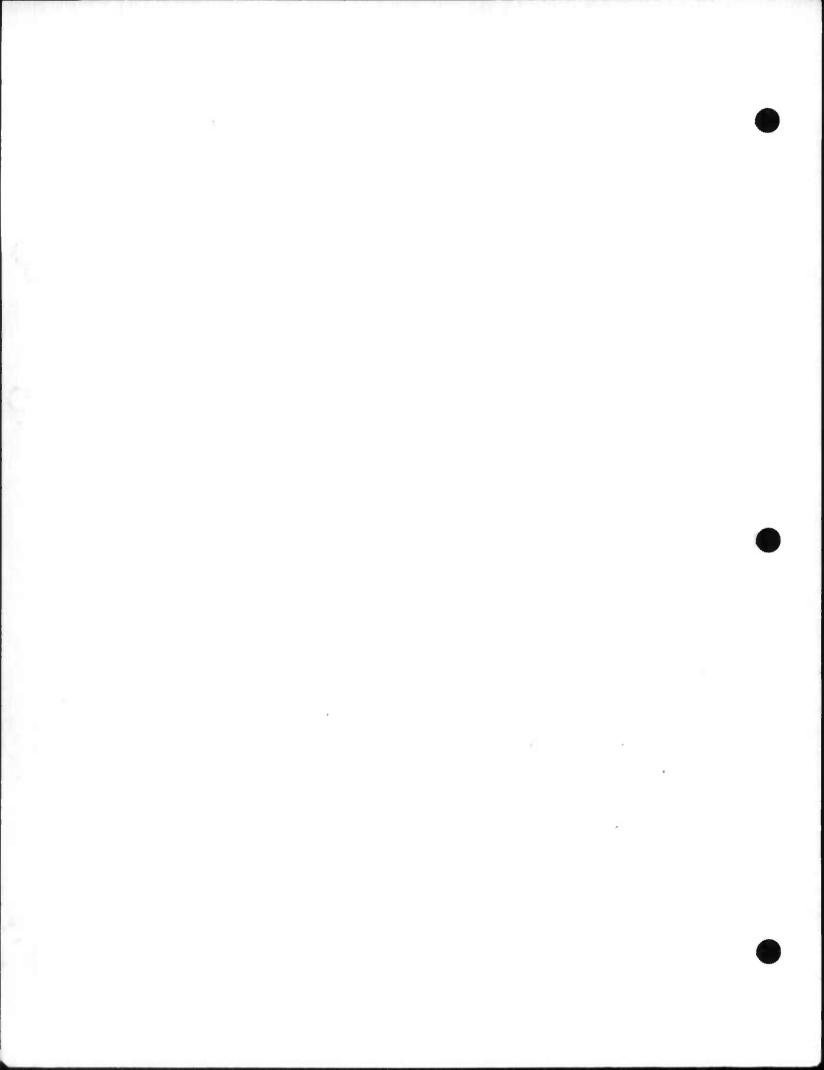
10g, CITIZEN OF WHAT COUNTRY?

United States

9c. COUNTY OF DEATH

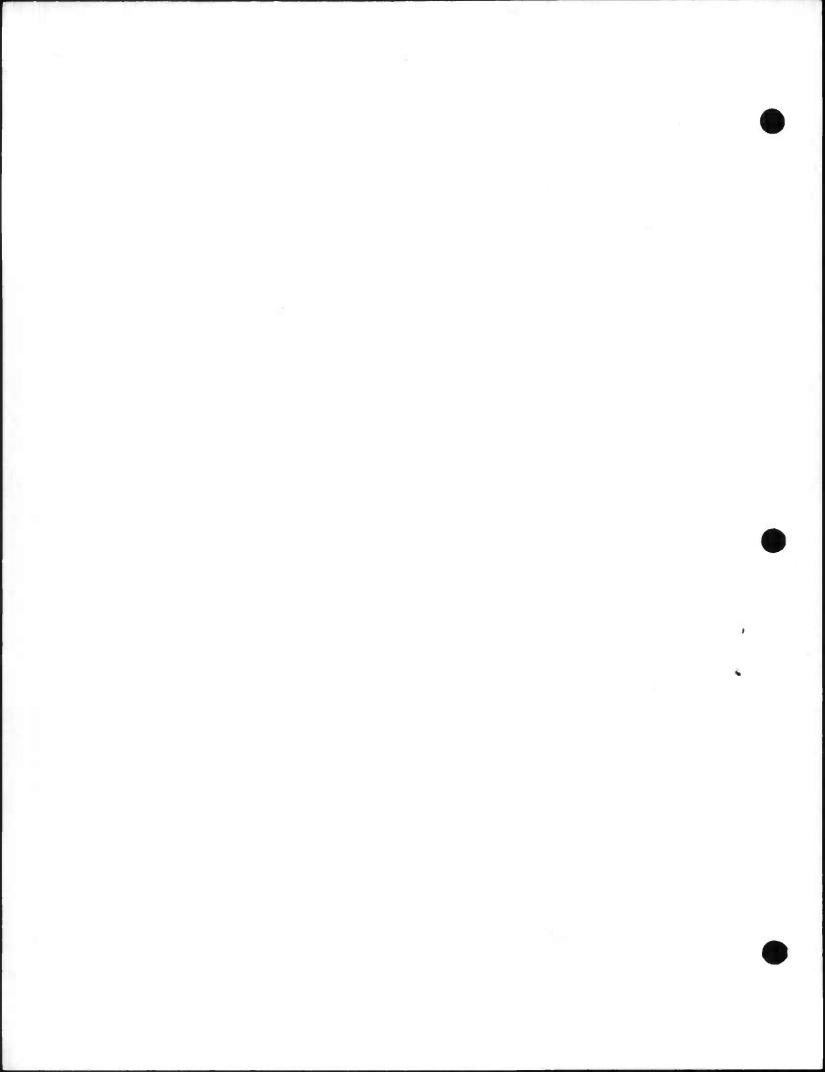
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| | | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|--|---------------|--|---|------------------------------------|--|--|---|--------------------|--|----------------|
| | | 11.11 | ENOCI | | | | 2. DATE OF DEATH | DAY Y | 3. TIME OF DEATH | A M |
| pino | | | □ M 2 □ F 6 | (In yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morth, Day, Year) April 1,1 | 1927 W | BIRTHPLACE (State or Fore Country) ashington, D | |
| 1, 2, 3 should | TOR | 10119 Greenock Road | | | | or Location of DE | ATH | 9c. COUNTY | of DEATH | |
| permit. Pages 1 | DIRECTOR | Maryland Montgom | nery | | ry, town on Local Silver S | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 N | ю |
| isi | FUNERAL | 10. STREET AND NUMBER 10119 Greenock Road | | | 10 | 20901 | | U.S. | N OF WHAT COUNTRY? | |
| 215-0020 attending physician. se as the burial-transit | B | 1) Never Married 2 Married | . WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | CENDENT OF HISPAN pecify Cuban, Maxicai S 2 NO Specify | | es or No.— 14. | . RACE — American Indian, Black, White, atc. Specify: White | l _s |
| 21215 | LETED | | ollege (1-4 or 5+) | (Give kind of v life. Do NOT us | | ost of working | | USINESS/INDUST | TRY | |
| YLAND Soft by the hospital be detached for at once. | COMPL | 12 17. FATHER'S NAME (First, Middle, Last) MIchael A. Delleno | | Administ | rative A | 16. MOTHER'S NAI | ME (First, Middle, Maide | n Sumame) | Monetary F | und |
| MAR retained 5 should notified | TO BE | MICHAEL A. DELLENO 19a. INFORMANT'S NAME (Type/Print) Anna D. Gallo | <u>c1</u> | | | and Number or Rural R | la M. Masi Poute Number, City or To Silver Sp | wn, State, Zip Coo | aryland 209 | 0.1 |
| MORE, I age 6 may be director, page or must be r | | 20a. METHOD OF DISPOSITION 10 Burial 2 Cremation 3 Removal 1 4 Donation 5 Other (Specify) | from State come Ga1 | PLACE AND DATE | of disposition (No other place) aven Cen | metery 1 | DATE 20c. LO | OCATION — City | | |
| AD L 2 7 1 | | 21. SIGNATURE, OPPSMERAL SERVICE LICENSE | Klibel | | Franci 500 Ur | is J. Col niversity | aur lins Fune BlvdW. | ral Hom | ne, Inc. | |
| within 24 hours within 24 hours applied in I cremation, or re vent, the med | | 23. PART I. Enter the diseases, or companock, or heart failure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) | OVACIAL | sch line. | inot enter the mo | ode of dying, such |) as cardiac or resp | piratory arrest | Approximate Interval Bett Onset and I | ween Death |
| P.O. BOX 68 h certificate be execute ending physician and or Hygiene prior to buria or other traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | CONSEQUENCE OF | | | | | | |
| T P P E | MEDICAL C | PART II. Other aignificant conditions con | intributing to death bu | at not resulting i | in the underlying | g cause given in I | | PRMED? | 24b. WERE AUTOPSY FIND AVAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? | USE |
| AN: The law requires sincate has been signs state Dept. of Healt if them 23 shows if | SICIAN: M | DID TOBACCO USE CONTRIBU | 2 | F DEATH YE | | | 10 | | 1 TES 2 NO | , |
| ICIAN: The Sertificate hithe State or Item | PHYSIC | _ NO | OSPITAL: Inpatient 2 ER/Outpa | | | ne 5 🗆 Residence (| | | | |
| PHYS E | ВУ РЬ | 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | | M 1 1 | YES 2 NO | 26d. DESCRIBE HOW | | | |
| DIVISION DIRECTOR: After hours after death item 28 is mai | B | 3 Suicide 6 Could not be detarmined | 26a. PLACE OF INJURY - building, atc. (Specif | Hy) | | | 281. LOCATION (Street City or Town, State | 0) | Rural Route Number, | |
| 4 4 Z | COMPLET | (Check only one) 2 MEDICAL EXAMINER: On | | | | death occured at the t | time, data and place, as | and due to the ca | | ed. |
| TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT. | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER | <i>[</i> | | | 29c. LICENSE NUM | BER | 29d. DATE SIG | GNED (Month, Day, Year) | |
| | | 30. NAME AND ADDRESS OF PERSON WHO COMBRUCE R. Kressel, N 31. DATE FILED (Month, Day, Vear) | M.D. 5480 |) Wiscons | | ue #214 | Chevy Cha | ase,MD | 20815 | |
| | | JAN 2 9 1996 | Febri Devolson | Randall | | | | | | |



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CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE 2

27. MANNER OF DEATH

5 Pending

1 Watural

2 Accident 3 Suicide

4 Nomicide 29e. CERTIFIER

DIVISION OF VITAL RECORDS, P.O. BOX 68769

| | Page | | |
|---|---|---|--|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Page | within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPOUTANT 16 Home 20 to marked or them 20 shows one interes or other bearmosts seems the model or marked to marked to an interest of the model of the marked to marked to the contract of the marked to the contract of the marked to the contract of the marked to the contract of the contra |
| THE HO | 표 | filed wit | PODTA |
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96 03699 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH ADIAN SUNA as UAC Saw 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 M 2 💭 579-44-0027 90 March 19,1905 Lithuania 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 314 Timberwood Avenue Silver Spring Montgomery RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring Maryland Montgomery 1 YES 2 0 NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 314 Timberwood Avenue 20901 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Merried 3 Widowed 4 Divorced Specify White 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (8-12) College (1-4 or 5+) 5+ Social Worker Private Industry 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Sumame) Unknown Caplan Unknown 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan David 818 Dennis Avenue Silver Spring, Maryland 20a. METHOD OF DISPOSITION
150 Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other Section 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State cemetery, cremetory or other plece)
Parklawn Cemetery Donation 5 Other (Specify) _ 1/28/96 Rockville, Maryland 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSES Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil.Spr., MD 20901 22. PART I. Enter the di complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximats shock.see Interval Between IMMEDIATE CAUSE (Final Onset and Daath disease or condition tone ears resulting in death) DUE TO (OR AS A CONSEDUENCE OF) Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF QEATH?

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 | YES 2 | NO

(Street end Number or Rural Route Number,

| WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATN (Check only one) | | | | | | |
|---|---|--------|-----------------|--|--|--|--|
| | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: | 5 Residence 6 0 | | | | |

28e. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d, DESCRIBE NOW INJURY OCCURED 1 YES 2 NO

| investigation | | |
|---------------------------|--|------------------------------|
| 6 Could not be datermined | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | 26f. LOCATION City or Tow |
| | | |

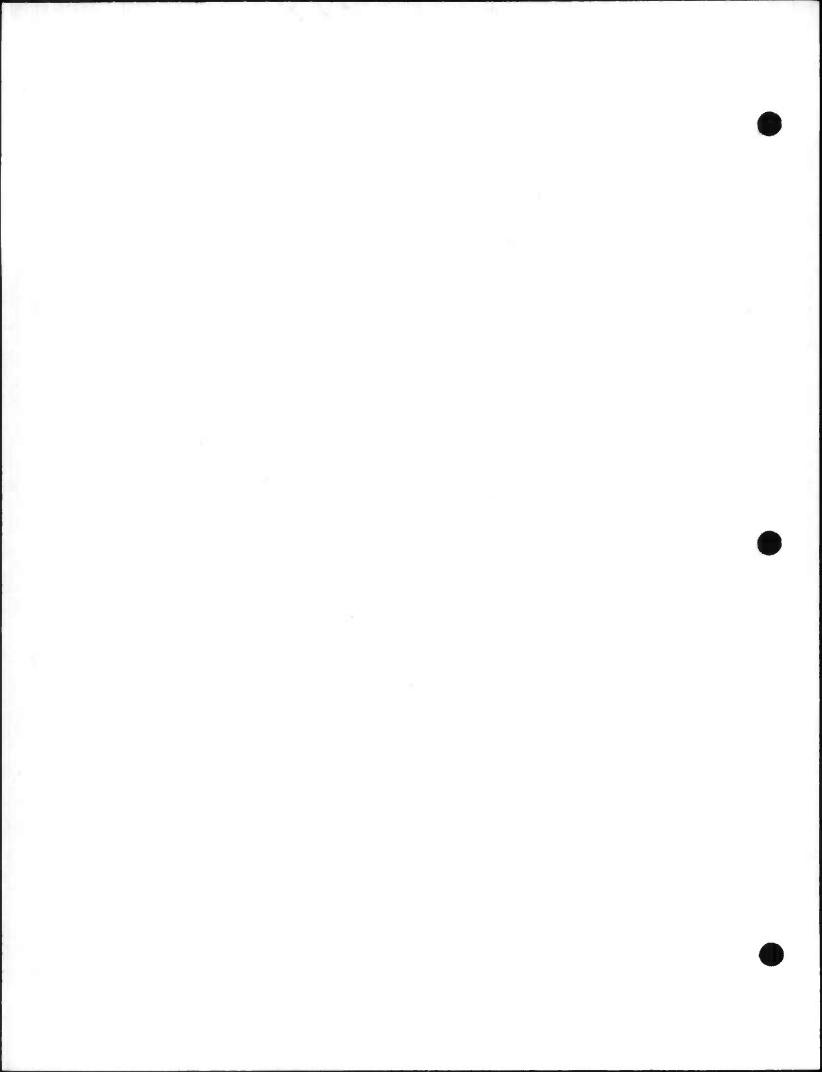
| 1 CERTIFYINO PNYSICIAN: To the beat of m | y knowledge, death occurred at the time, date | e end place, | end due to the cause(s) end man | ner es stated. |
|--|---|--------------|---------------------------------|----------------|
| A Transport Systems & | | | * * | |

| 2 MEDICAL EXAMINER: On t | he basis of exemination of | end/or investigation, | In my opinion, death occured at the time, date end place, | end due to the ceuse(e) end menner ee stated |
|---------------------------------------|----------------------------|-----------------------|---|--|
| | | | | |
| 29b. SIONATURE AND TITLE OF CERTIFIER | | \ | 29c LICENSE NUMBER | 294 DATE SIGNED (Month One Man) |

| | | | | | 47 |
|--------------|------------------|----------------|-----------------------------|---------------|----|
| 30. NAME AND | ADDRESS OF PERSO | ON WHO COMPLET | ED CAUSE OF DEATH (ITEM 27) | (Type, Print) | |

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| JAN 29 1996 | File CHARLESIGN ARE |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.0 0.7 0.0

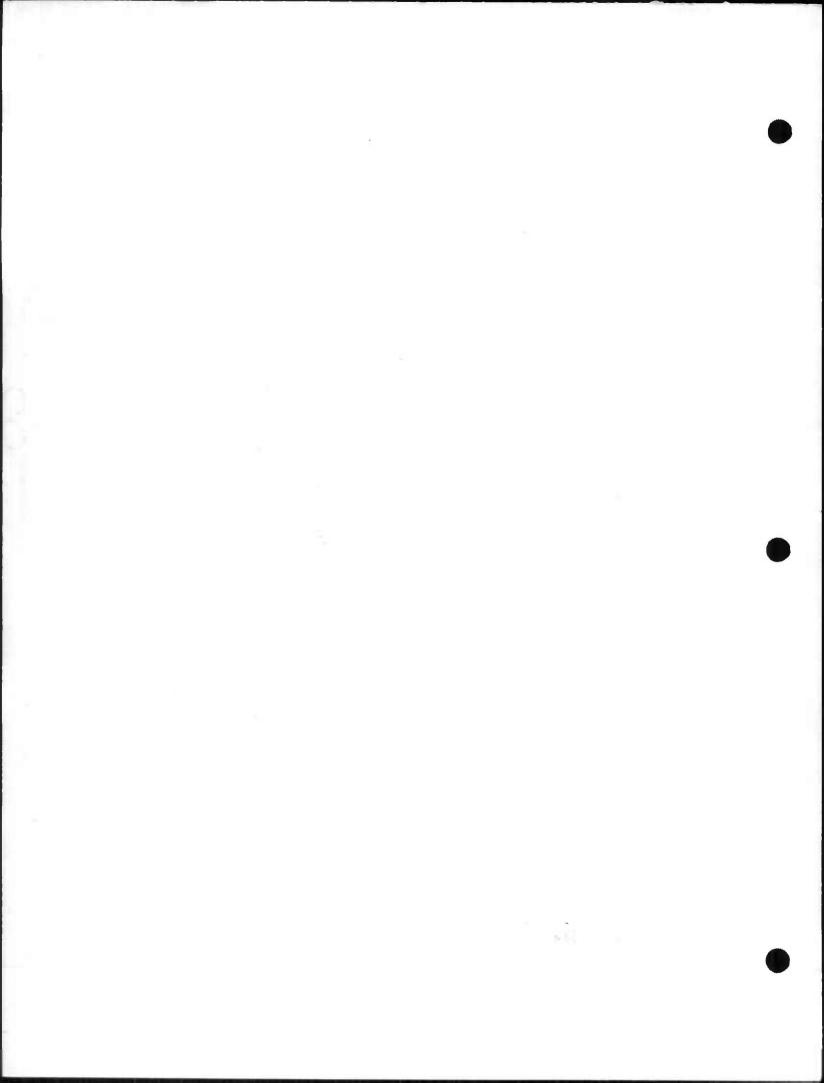
| _ | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Certificate | of | Death | | Reg. No. |) (| 3700 | | | | | | | | | | | | | | |
|--|--|-----------------------|--|---|---|--|----------------------|--|-------------------------------------|------------------------------|-------------|--------------------------------------|-----------------|----------------------------|--|------------------------|--|--|------------------|--------------------|---------|----------------|--|--|--|-----------------------|
| | Physic | | 1. Decedent's Name (First, Middle, La MARGARET | Louise | - | EV | AI | VS | 2. Date of Do Month JANUAR | Day | Year 996 | 3. Time of Death 6:20 PM | | | | | | | | | | | | | | |
| | /Medi Examiı <i>⊂</i> | | 4a. Facility Name (If not institution, giv 7824 Marlboro P | | | | | 4b. City, Town, or L Forestvil | ocation of Dear | th 4c. County | of Death | ORGE'S | | | | | | | | | | | | | | |
| | Funeral Director | | 3/9-42-1/00 | D | in yrs. lest birtl 88 Y | hdey) If Under 1 Months I | Year Deys | If Under 24 Hrs. Hours Min. | 8. Date of Bi (Month D OCT 18 | irth ay, Year, 1908 | 9 Birth | place (State or Foreign | | | | | | | | | | | | | | |
| Maryland -f ahow | Maryland of ahow | tor | Usuel Residence of Decedent 10a. State 10b. County Maryland Prince G | | oc. City, Town Forest | | | | | | 1 | 10d. inside City Limits 1 ☐ Yes XXNo | | | | | | | | | | | | | | |
| | ath with the | Funeral Director | 10e. Street and Number 7824 Marlboro Pi | ke | | 10f. Zip C | 20 | 747 | | 10g. Chizen of V United S | | • | | | | | | | | | | | | | | |
| 020 | d within 72 hours after death with the Maryland jiene. r than "natural", or farms 23a or 28a-f show the Medical Examiner must be notined at | by | 11. Marital Status 1 □ Never Merried 2 □ Married 3 ◯ Widowed 4 □ Divorced | 12. Was Decedent Eve Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: | er in U,S. | 13. Was Deceder If Yes, specify | | dispanic Origin? (Spen, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | Specify | k, White, | can Indien, etc. | | | | | | | | | | | | | | |
| Maryland 21215-0020 | within ane. than | Completed | 15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12) 9th | ducation ade completed) College (1-4or 5+) | | Decedent's Usuai ((Give kind of work life. DO NOT use ate Cash | retire | * | king | 16b. Kind of Bu | usiness/in | dustry | | | | | | | | | | | | | | |
| /land | uld be filed Vental Hygin rked other rtic avant, II | To Be Co | 17. Father's Name (First, Middle, Last, John William Dav | | | | | 18. Mother's Nam Elizabet | | | | | | | | | | | | | | | | | | |
| | permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Itam 27 Is marked other any Injury or other traumatic avant, 2006. | | 19e. Informent's Neme/Relationship (Emily Jimney | | 660 | | Pl | and Number or Run ace, FRre | stville | e,Md 207 | 47 | | | | | | | | | | | | | | | |
| altimore, | it. Pages intmant of h intent: If its injury or of | | 20a. Method of Disposition 1 ☑ Suriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications) 21. Signature of Funeral Servica Line | Removal from State (y) | cametery | nabas Cen | er pla net | ery Jan 2 | | | arlbo | oro,Md | | | | | | | | | | | | | | |
| Ba | Depa Impo any is | | MISO. | tall | e death Don | Alexandr | ria | Ferry Ro | ad,Clir | nton,Md | | | | | | | | | | | | | | | | |
| | Physician /Medical Examiner | ler. | 23a. Part1. Enter the diseese, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | .GENERALIZ | ed ATV | | | | | | e | Interval Between Onset end Death | | | | | | | | | | | | | | |
| x 68760, | certificate be axecuted inding physician and use as the bunal-transit | /Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | C | | onsequenca of): | | | | | | | | | | | | | | | | | | | | |
| P.O. Box | death e atter | oleted by Physician/M | by | by | by | by | | by | | | | | | | | | Part II. Other significant conditions of | ontributing to death but r | not resulting In | the underlying cau | ıse giv | ven in Part I. | | | | o the cause of death? |
| Records, | requires been sign should be | | | | | | | | | | | | | | | s an autopsy ormed? | ev | fere autopsy findings vailable prior to impletion of cause deeth? | | | | | | | | |
| Vital Re | ilclan: The law certificate has b rector, page 2 s | | 25. Was case referred to medical | | | | | On Place of Page | | Yes 2 No | 1 (| ☐ Yes 2☐ No | | | | | | | | | | | | | | |
| sion of tending Phys leath. tor: After this the funeral di | | rtification: To Be | P | P | 2 | 2 | Certification: To Be | examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide examiner? 5 Pending Investigation 6 Could not b determined | | - At home, far | ime of 28c | Vo. Inju | 4 LI Nursing Ho | ome 5 Res 28d. Describe | idence 6 Oth how injury occur (Street and Numb | red | | | | | | | | | | |
| | To the Hospital or Att within 24 hours after of To the Funeral Diract completely filled in by | edicai | (Check only 20 Madical Even | ysician: To the best of n niner: On the besis of ex and manner stated | menination and | for Incombination in | | minion death near | mand at the sime | data and alone | and due t | a the severalet | | | | | | | | | | | | | | |
| • | To the Total | M | 29b. Signature and title of cartifier Server M 30. Name and address of person who JRENGER MD 31. Date filled (Month, Day, Year) JAN 3 0 1 | ID | | 29c. L | 2.5 | se number 5925 | | 29d. Date signe Tauwany | 26, | Day, Year) | | | | | | | | | | | | | | |
| | | | 30. Name and address of person who | completed cause of deet 205 , 77 : | th (Item 23a) (T | Type, Print) I S CON S IN | A | ve, Bei | hesda | , Md. 2 | 0814 | f | | | | | | | | | | | | | | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) JAN 3 0 1 | 996 32. Registrar's | Signature | Rardall | | | | | | | | | | | | | | | | | | | | |

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| | ages 1, 2 | |
| | sician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pa | |
| sician. | rial-transit | |
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| HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | ould be o | |
| y be reta | age 5 st | |
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| execute | n and co | to burial |
| ficate be | physicia | ne prior |
| eath certi | attending | rith the State Dept. of Health and Mental Hygiene prior t |
| it the d | by the | and Me |
| thires the | certificate has been signed by t | Health ; |
| aw rec | s beer | ept. of |
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| 분 | JH. | pel |

| | | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | MENTAL HYGIEN | E · | | |
|---|------------------|---|---|-----------------------------------|-------------------------------------|-----------------------------|---|----------------|------------------------|--|
| _ [| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DO | | YEAR 3. T | IME OF DEATH |
| | | DEANE | | | EVAN | IS | January 20 | | | :30A M |
| D | 1 | | 5. SEX 8. AGE (III | yrs. iast birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Jan 14, | 1904 | Country) | E (State or Foreign |
| 3 should | | Se. FACILITY NAME (If not institution, give stre | et and number) | | 9b. CITY, TOWN | OR LOCATION OF DE | EATH | 9c. COUNT | Y OF DEATH | |
| 1, 2, 3 | DIRECTOR | Memorial Hospital | & Medical Ce | enter | Cumberl | and | | Alle | gany | |
| permit. Pages | JIRE | MD Alle | egany | 1000 | y, town on Local umberlan | | | | | INSIDE CITY LIMITS? YES 2 NO |
| ermit. | | 10e. STREET AND NUMBER | garry | | | r. ZIP CODE | | 10g. CITIZE | N OF WHAT | |
| 15 | ER/ | 1 Baltimore Stre | et | | | 21502 | | USA | P | |
| 21215-0020 al or attending physician. for use as the burial-transit | BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 M Merried 3 Widowed 4 Divorced | 12. WAS OECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2X NO | It yes, sp | | NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | or No- 1 | Black, Whi Specify: | merican Indien, ite, etc. |
| r attendi | ED | 15. DECEDENT'S EDUCA (Specify only highest grade of | | 16e. DECEDENT'S | USUAL OCCUPATION | ON | 16b. KIND OF BU | SINESS/INDU | | 1100 |
| # 8 B | COMPLETED | Elementary/Secondery (0-12) | College (1-4 or 5+) | life. Do NOT u | work done during mo se retired.) | ost of working | | | | |
| AND 2 the hospital detached to once. | MP | 12 | | Forme | er Employ | | | ersity | Y | |
| YLAND by the hospit be detached at once. | | 17. FATHER'S NAME (First, Middle, Last) | | | | ALL PERCENTIFIED | ME (First, Middle, Melden | Surname) | | |
| | BE | William Ward 19e. INFORMANT'S NAME (Type/Print) | | 195 MAIL INC | ADDRESS (Street) | | (Rumer) Route Number, City or Yow | n State 7in C | Cordel | |
| MAR retained 5 should notified | 2 | Janice Keech | | | | | e; Cumberla | | | 502 |
| ORE, I 6 may be ector, page | | 20e. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Remove | | PLACE AND DATE | OF DISPOSITION (N | | | CATION - CI | | |
| MORI ge 6 ma lirector, p | | 4 Donation 5 Other (Specify) | | etery, crematory or c Restlawn | Memoria | al Garder | 10 | aVale, | , MD | |
| BALTIMORE, er death. Page 6 may be the funeral director, page val. | | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | 21/1 | 22. NAME A | ND ADDRESS OF FA | outy ineral Home | 2 | | 6.0 |
| | | Janes - | 1 XICar | Myli | Cumb | perland, | MD 21502 | | | |
| urs at in by r rem | | 23. PART I Enter the diseases, or co shock, or heart failure. L | emplications that caused ist only one cause on ea | the death. Oo ch line. | not enter the mo | ode of dying, suc | h as cardiac or resp | iratory arres | et, | Approximate Interval Batwean Onset and Death |
| the the | | iMMEDIATE CAUSE (Final disease or condition resulting in death) | End to | toge | CH | F | | | į | Jnknown |
| N 8 5 - 6 | | | DUE TO (OR AS A | CONSTRUIENCE O | F): | | | | | |
| 68 xecu burn burn | ION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE O | ⊮F): | | | | | Jnknown |
| BOX cate be e hysician is prior to | SAT | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | | |
| oth of the | CERTIFICATION | that initiated eventa resulting in death) LAST | DUE TO (DR AS A | CONSEQUENCE D | F): | | | | | |
| DS, P. he death of the attend Mental Hy njury, or | CER | d | | | | | | | | |
| 4, 24 3 | AL | PART II. Other algolificant conditions | contributing to death bu | it not resulting | in the undarlyin | g cause given in | Part I. 24a. WAS AN PERFOI | | AVAI | E AUTOPSY FINDINGS LABLE PRIOR TO |
| RECORD requires that the seen signed by th of Health and It shows any Inj | PHYSICIAN: MEDIC | | | | | | 1 _ YES ; | NO | | PLETION OF CAUSE DEATH? |
| REC v requir been si | M | DID TOBACCO USE CONTR | IRLITE TO CALISE OF | E DEATH V | ES [] NO [| UNCERTAI | M D | | 1 🗆 | YES 2 NO |
| AL has the Dept | IAN | 25. WAS CASE REFERRED TO MEDICAL | | | TH (Check only one) | | | | <u> </u> | |
| F VITAL SICIAN: The lan certificate has the State Dep | SIC | | HOSPITAL: | itlent 3 🗆 DOA | OTHER: 4 - Nursing Hon | ne 5 🗆 Residence | 6 Other (Specify) | | | |
| . O 5 E | PHY | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. Till | | JURY AT ORK? | 28d. DESCRIBE HOW | INJURY OCCU | JRED | |
| ON OF DING PHYSI After this c death with | BY | 2 Accident 5 Pending Investigation | | | | YES 2 NO | | | | |
| TTENDI TTOR: A after d | COMPLETED | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY building, etc. (Speci | — At home, ferm, | atreet, lectory, offic | te . | 261. LOCATION (Street City or Town, State, | | r Rurel Route | Number, |
| DIV AL OR A L DIREC 2 hours f item | PLE | | IAN: To the best of my knowle | edge, death occur | red at the time, dete | e end place, end due | to the cause(e) end ma | nner ee stated | d. | |
| HOSPITAL FUNERAL Within 72 TANT: If | SON | one) 2 MEDICAL EXAMINER | On the beele of examination | end/or investigati | on, in my opinion, o | death occured at the | time, date end place, er | nd due to the | ceuse(e) end | menner es stated. |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 I | BE (| 29b. SIGNATURE AND TITLE OF CONTIFIER | | | | 29c. LICENSE NU | MBER | 29d. DATE | SIGNED (Mog | oth Day, Year) |
| TO THE De filed IMPOR | 0 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | TH (ITEM 27) (3 | Print) | D 28910 | | Ja | Ma | 4/16 |
| 2 | | | Memorial Ho | | | Ruilding | c Cumberla | nd. MD |) 21 | 502 |
| MAS | | Dr. H. C. Merrick | 32/ARGISTRAR'S SIGNA | ATURO | Heurcar | Dattatus | 5 Cumberra | in en | 1 | |
| | | 1WM 9 T 1920 | Just made | n "Pulled Hally | | | | | | |





BOX 68760 BALTIMORE, MARYLAND 21215-0020 ficate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Linst) FIORENCE M. EN | GLISH | | | | | | | 2. DATE OF DE | EATN 29, | 1996 ^{AR} | 3. TIME OF OEATH 12:10 P M | |
|---------------|---|--|-------------------------------------|-------------------------|---|------------|------------------------|------------------------------|--|----------------------------------|--------------------|--|--|
| | 4. SOCIAL SECURITY NUMBER 195-32-0505 | 5. SEX 1 M 2X F | 6. AGE (In yrs. las | t birthday) YRS. | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF BI | 5, 19 | 00 8. BHP | TNPLACE (State or Foreign ntry) PA | |
| OR | 9e. FACILITY NAME (If not institution, give st MEMORIAL HOSPIT | | | | | | R LOCATI | | _ | | ALLEX | SANY | |
| DIRECTOR | 10a. STATE 10b. COUNTY MD All | .egany | | | ry, town o | | TION | | | | | 10d. INSIDE CITY LIMITS? 1X YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 31 Richard Way | | | | | 10 | 215 | | | 10 | USA | WHAT COUNTRY? | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? | NT EVER IN U.S. AR | MED | 1 18 | If yes, sp | ENDENT (ecity Cub- | in, Mexica | NIC ORIGIN? (Sp in, Puerlo Rican, y: | ecity Yea or f etc.) | Ble | CE — American Indian, ack, Whita, atc. actly: white | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | +) (G | ive kind of Do NOT u | work done ise retired.) | during mo | ON Isl of worki | ng | | OF BUSINE | me | 15% | |
| COM | 17. FATNER'S NAME (First, Middle, Lest) | | | | | | 18. MOT | | ME (First, Middle, | | | 4724 | |
| BE | John Neibaue: | r | | | | | | | garet (| | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | NG ADDRESS (Street and Number or Rural Route Null Richard Way; LaVale, | | | | | ty or Town, St 2150 | | | |
| | Margaret Bevans 20. METNOD OF DISPOSITION 1X Burlal 2 Cremetion 3 Ram 4 Donation 5 Other (Specify) | | 20b. PLACE | AND DATE | OF DISPOS | SITION (N | ime of | | OATE | 20c. LOCATI | ON — City or | Town, State Le, PA | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSES With A Manual And Address of Facility Scarpelli Funeral Home for Nice Cumberland, MD 21502 | | | | | | | | | | | | |
| | 23. PART I. Enter the disease, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ca | senteric | Arte | erial | | | | ch aa cardlec (| or respirate | errest, | Approximate interval Batween Onget and Death 24 hrs. | |
| N | Sequentially list conditions, | Ath | eroscle | elerosis | | | | | | | | 10 yrs. | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c | O (OR AS A CONSE | | | | | | | | | | |
| EH | reaulting in death) LAST | d | | * | | | | | | | | | |
| MEDICAL | old age; senil | _ | | reaulting | in the u | nderlyin | g cause | given in | | WAS AN AUT PERFORMED YES X |)? | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| | DID TOBACCO USE CONT | RIBUTE TO CA | AUSE OF DEA | TH Y | ES 🗆 | NOX | X UN | CERTAI | N 🗆 | | | | |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | R: | | | | | | | |
| BY PHYSICIAN: | 1 YES 2 XMO 27. MANNER OF DEATN XXNetural 5 Pending 2 Accident Investigation | 28a. DATE O | ER/Outpatient 3 F INJURY Day, Year) | 28b. TII | | 28c. IN | JURY AT ORK? | | a Other (Spe 28d. DESCRIE | | RY OCCURED | | |
| | 3 Suicide 8 Could not be 4 Nomicide datermined | OF INJURY — At he p, atc. (Specify) | ome, farm, | street, fac | ctory, offi | ia . | | 28f. LOCATION City or Tox | | Number or Run | el Route Number, | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated. | | | | | | | | | | | e(s) and manner as stated. | |
| 8 | 29b. BIGMATURE AND TITLE OF CERTIFIE | (anjsthe | | | | | | 1931 | | 29 | | ED (Month, Day, Year) | |
| 요 | Dr. N.A. Ranjit | han; 51 | 7 Oldtow | n Roa | ad; (| Cumb | erla | nd, l | MD 2150 | 2 | | | |
| | JAN 9 0 1996 | REGIST | AR'S SIGNATURE | LK | | | | | | | | | |

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| DING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|---|--|
| | er this certificate ha | ith with the State D | narked, or Item |
| IL OR ATTENDIN | HE FUNERAL DIRECTOR: After this | 2 hours after dea | f item 28 Is n |
| TO THE HOSPITAL OR ATTENDING PHYSIC | THE FUNERAL | be filed within 72 hours after death with the | IMPORTANT: II |

| | for STATE REGISTRAR | STATE OF MARYL | AND / DEPARTA CERTIFIC | | | MENTAL HYGIEN | | | |
|---------------|--|---|---|----------------------------|------------------|--|---|----------------|---|
| | 1. OECEDENT'S NAME (First, Middle, Last | n | | | | 2. DATE OF OEATH | AY | YEAR | 3. TIME OF DEATH |
| | MARY T. | EASTERLING | | | | JANUARY 29 | | 96 | 7:40 P ^M |
| | 365-22-9905 | 1 □ M 2X-XF 8: | YRS. | UNDER 1 YEAR INTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 1AR. 31,19 | | MIC | HIGAN |
| 5 | 9e. FACILITY NAME (If not institution, give SACRED HEART I | | 91 | | RLAND | EATH | | LEG | |
| DIRECTOR | 10e. STATE 10b. COUN | ITY | 10c. CITY, T | OWN OR LOCAT | ON | | | | 10d. INSIDE CITY |
| AL DIR | MICHIGAN SAC | GINAW | ST | . CHAR | LES ZIP CODE | | Inc. CiTi | ZEN OF W | 1 X YES 2 NO |
| F | 8400 S. HEMLO | CK ROAD | | | 48655 | | 100 | S.A | |
| BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced | 12. WAS DECEOENT EVER III FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | If yes, spe | NOENT OF HISPAN | NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | _ | | — American Indian, White, etc. |
| ETED | 15. DECEDENT'S EC (Specify only highest gra | ide completed) | 16e. DECEDENT'S US (Give kind of work life. Do NOT use re | done during mos | | 16b. KIND OF BU | SINESS/IND | DUSTRY | MIIII |
| 3 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | HOMEMA | | | HOME | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | | |
| BE C | ALBERT HAVEN | | | | THERE | SA MURPHY | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | - | | | | Route Number, City or Tow | | | 0.57.50 |
| | MARILYN WETMOR | | #1 S | | | RT - RIDO | CATION - | | |
| | 1 Surial 2 Cremation 3 Re | | etery, cremetory or other | plece) | | 1/2/2 | IEML (| | |
| | 21. SIGNATURE OF FUNERAL SERVICE | | MARY | | D ADDRESS OF FA | CILITY | | | |
| | > Wondy 8 | A Yearhung | 1. | | | URCH FUNE ST.,CUMBE | | | |
| | 23. PART I. Enter the diseases, o | r complications that cause | 1 tha death. Do not | enter the mo | te of dying, suc | h aa cardiac or reap | Iratory arr | reat, | Approximate |
| | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | e. Liet only one cause on e | sgass | YVC | Au | A for | Ri | ٤ | Interval Between |
| CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | LDI | Ken | Hior | CVAS | Zuls (1819) | LINKNOWN JUNKNOWN JUNKNOWN |
| MEDICAL | Well tis | Englas | x footby | 10 | cause given in | Part I. 24e, WAS AN PERFOI | RMED? | 24b. | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ij | DID TOBACCO USE CON | TRIBUTE TO CAUSE O | | | UNCERTAI | N 🗆 📗 | | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 28. PLACE OF DEATH | THER: | | | | | |
| Z L | 1 YES 2 NO 27. MANNER OF DEATH | Inpetient 2 ER/Outs | 28b, TIME O | | | 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OC | CURED | |
| - 1 | Netural 5 Pending | (Month, Day, Year) | INJUR | Y WO | RK? ES 2 NO | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| ED B | 2 Accident Investigation 3 Suicide 8 Could not b 4 Homicide determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, larm, stre | e1, factory, office | | 281. LOCATION (Street City or Town, State | and Number | or Rural R | loute Number, |
| COMPLETED | onel only | YSICIAN: To the best of my know | | | | | | |) and manner as stated. |
| O BE C | 29b. SIGNATURE AND TITLE OF CERTIF | VER MS. MSG | Le | A | 29c. LICENSE NUI | MBER 980 | 29d. DAT | E SIGNED | (Month, Day, Year) |
| - | 30. NAME AND ADDRESS OF PERSON V | WHO COMPLETED CAUSE OF DE | CATH (ITEM 27) (Type, Pr | oni | ns 211 | 5021 | | | |
| | JAN 3 0 1996 | SZ REGISTRAR'S SIGN | A A A A A A A A A A A A A A A A A A A | | | | | | |

ITEM: 1. PER F.H. 31. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. FILM G-732 2/9/96 t.t State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last)
 VERGIE 2. Date of Death **Physician** Month Year Virginia VIRGIE FREEMAN FEBRUARY 6, 1996 12:50pm /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HARFORD MEMORIAL HOSPITAL S.UNION AVE HAVREDDE 2 GRACE HARFORD If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 9. Birthplace (State or Foreign Country) Virginia 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Days 1 M 2 F Director 218-26-2037 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at Maryland Darlington, Maryland Harford 1 ☐ Yes 2 No Director 10f. Zip Code* 21034 10e. Street and Number 10g. Citizen of Whet Country? 4104 Conowingo Road USA Items 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritei Stetus 72 hours after 1 ☐ Never Married 2 N Married 8 Baltimore, Maryland 21215-0020 White 1 ☐ Yes 200No Specify: þ 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry liled within 7 Hygiene. permit. Pages 1 and 2 should be lited within Department of Health and Mental Hygiene important: If Item 27 is marked other than any Injury or other traumetin. Elementery/Secondary (0-12) Coilege (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Baxter D. Owens Flora Price 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4104 Conowingo Road, Darlington, Md. 21034 Eli Freeman / husband 20a. Method of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State Stewartstown Cemetery 2/10/96 Stewartstown, Pa. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name end Address of Facility J.J. Hartenstein Mortuary, Inc. 19 S. Main St., Stewartstown, Pa. 17363

Appropriate line.

Appropriate line. 23a. Pert1. Enter the diseese, or complication shock, or heart failure. List only one says Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue P.O. Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical signed by the aid be detached if Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown Records, þ certificate has been si rector, page 2 should I 24b. Were sutopsy findings aveileble prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 10 No 1 ☐ Yes 2 ☐ No 1 Yes **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Death 28a. Date of injury (Month, Dey Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certified 29c. License number

Haure de Grace, MD

State Registrar 31. Date filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

DHMH 16 Rav 6/95

BOX 68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician.

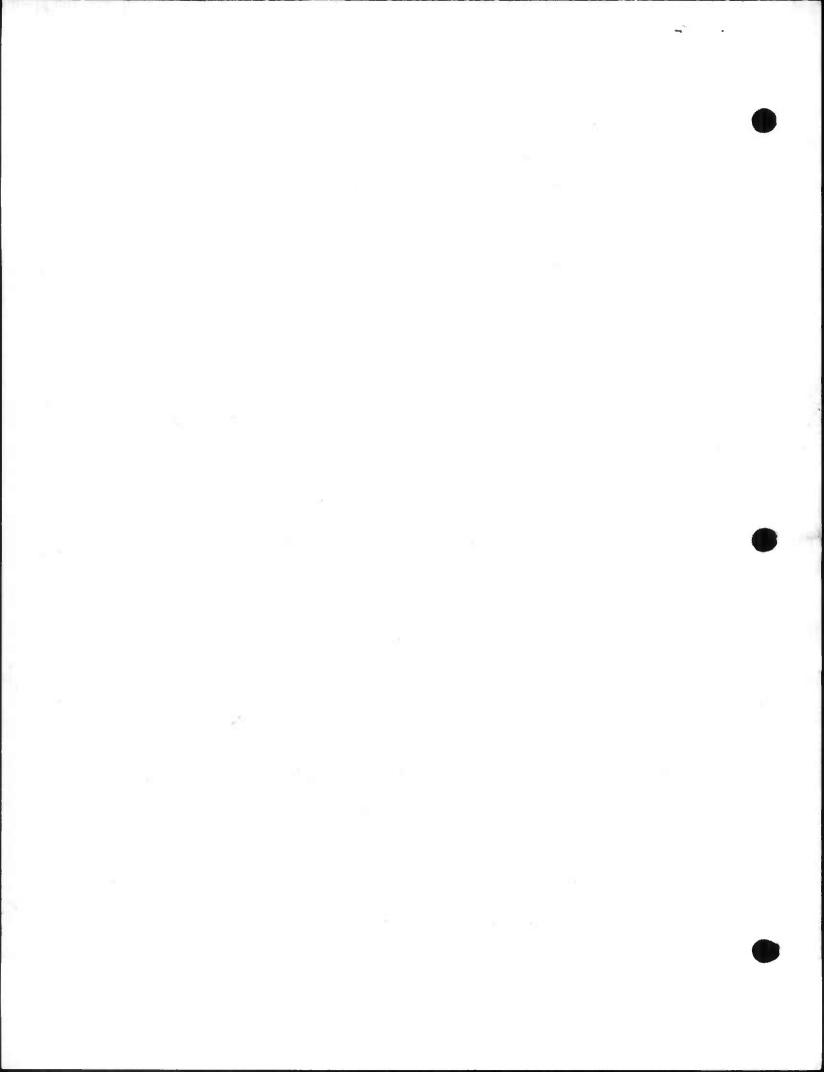
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| _ | HEGISTHAR | | UE | :KIIIF | ICALE | UF | DEAL | I H | R | EG. NO. | | | |
|---------------|---|-----------------------------------|-------------------------------|---------------------|--------------------|-----------------|--------------------|------------------------|-----------------------------------|----------------------|-----------|----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Luist) Henry Flynr | 1 | | | | | | | 2. DATE OF D | 25 | , 1 | 996 | 3. TIME OF DEATH 5:00 D M |
| | 4. SOCIAL SECURITY NUMBER 066–14–3024 | 5. SEX 6 | 75 AGE (In yrs. les | t birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. MIN. | 7. DATE OF B | 18TH 25' | 1920 | 8. BIRTH | PLACE (State or Foreign New York |
| OR | 9e. FACILITY NAME (If not institution, give s 1475 Harwell Aver | | | | | TOWN C | DR LOCATION | ON OF DE | | | 9c. COU | INTY OF D | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| DIRECTOR | Maryland Anr | y ne Arundel | | | r, town of | | TON | | | | | | 10d. INSIDE CITY LIMITS? 1XXYES 2 NO |
| A | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | E | | | 10g. CIT | IZEN OF V | WHAT COUNTRY? |
| FUNERAL | 1475 Harwell Aver | TUE | EVED IN U.C. 40 | 450 | Lan | | 2111 | | | | | USA | |
| B | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 12. | YES 2 N | IO IO | - 11 | yes, sp | ecify Cube | n, Mexican Specify. | IC ORIGIN? (Sp 1, Puarto Rican | ecify Yes , etc.) | or No- | 14. RACE Black Speci | E — American Indian, k, Whita, atc. #y: White |
| 쁘 | 15. DECEDENT'S EOU (Specify only highest grade | CATION completed) | 18a. OE | CEDENT'S | USUAL OC | CUPATIO | ON at of workin | a | 16b. KINI | OF BUS | INESS/IN | DUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) | college (1-4 or 5+) 4 years | life. | re l | e retired.) | | or or working | | co | nstr | ucti | on | |
| 0 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | IER'S NAM | ME (First, Middle | . Maiden | Surname) | | |
| BEC | Henry Flynn | | | | | | | | Tiern | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | loute Number, C | | | | |
| ٦ | Stephen Flynn | | | #50 | Cher | cywc | od C | ourt | State | n Is | land | , N. | Y. 10308 |
| | 20a. METHOD OF DISPOSITION 1 | oval from State | cemetery, cree | | her place) | | | | Jan. 29,96 | | | City or To | wn, Stata and, New York |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | 22. N | NAME AN | O ADDRES | S OF FAC | HLITY | | | | |
| | b Greyes. | 9 | | | | | | | eral H venue | | | ма | 20707 |
| CERTIFICATION | 23. PART I. Enter the diseases, or shock, or heert failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditione, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury | ELIET ONLY TO (O) | on each line. | ALLENCE OF | on one | the mo | bet me Fa | ky de | as cerdisc | or respli | ratory ar | reat, | Approximate interval Between Onset and Death |
| CERTIF | that initiated events resulting in deeth) LAST | · lulli | al // | aci | ul | hi. | Ac | lin | lint | | | | |
| ₽ | PART II. Other significent condition | s contributing to de | eath but not re | eeulting I | n the unc | deriying | ceuse g | lven in F | Part i. 24a. | WAS AN | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | | | | | | | | | _ 10 | YES 2 | -1 | | COMPLETION OF CAUSE OF DEATH? |
| ¥ | | | | | | | | | _ | | n. | | 1 TYES 2 NO |
| | DID TOBACCO USE CONT | RIBUTE TO CAU | SE OF DEAT | TH YE | S 🗆 N | 10 [| UNC | ERTAIN | I X | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | E OF OEAT | | | | | | | | | |
| <u>s</u> | 1 TYES 2 THE | 1 Inpatient 2 E | R/Outpatient 3 | □ DOA | OTHER 4 - Nursi | : Ing Home | 5 KRa | sidence 6 | Other (Spe | icity) | | | |
| BY PH | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 26a. DATE OF IN (Month, Bay) | JURY (Year) | 28b, TIME | OF M | 28c, INJI WO | 0/2 | NO | 28d. OEŞCRIB | E HOW IN | JURY OC | CUREO | |
| - 0 | 3 Suicide 8 Could not be 4 Homicide determined | 20s. PLACE OF II building, ato | NJURY — At hor : (Specify) | no, form. | Treet, facto | ry, office | | | 28f. LOCATION City or Tow | | nd Number | or Rural A | loute Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI CHECK ONLY 2 MEDICAL EXAMINE | CIAN: To the best of my | | | | | | | | | | |) and menner as stated. |
| O BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | chich | 4 | D. | | | 29c, LICE D 4 | IG (| BER FO | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| - | 30. NAME AND ADDRESS OF PERSON WH | | | | Print) | | | | 1/- | | | | |
| | Adolph Wychul 31. DATE FILEQ (Worth, Day, Ybar) AN 3 0 1996 | 32 REGISTRAR'S | astori Signature | | vd. | Ba l | Ltim | orc | , MD | 212 | 221 | | |
| | | - | | 76-1 | | _ | | | | | | | |



marked, BY

COMPLETED

BE

2

3 Suicide

4 Homicide

Pages 1, 2, 3 should

| 64 BALTIMORE, MARYLAND 21215-0020 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | i, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|---------------------------|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 6876 | cate be execut | prior to buni | er traumatic |
| P.O. | th certific | Hygiene | or othe |
| DS, I | the deat | d Mental | injury. |
| RECOR | requires that | of Health an | shows any |
| TAL F | The law I | ite Dept. | эт 23 s |
| F VIT | SICIAN | the Sta | d, or ite |
| ONC | ING PHY | eath with | market |
| VISIO | ATTEND | s after d | 1 28 is |
| Id | TAL OR | 72 hour | If Herr |
| | E HOSPI | d within | RTANT: |
| | H G | be file | IMPO |
| 1. | 1 | 0 | |
| 10 | de | 1 | |

96 03706 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF GEATH DAY 3. TIME OF DEATH YEAR FORT JANUARY 5:40 29 AM 1996 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 577-18-9080 1 🗌 M 2 💢 F YRS. Dec 23 MO 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MEMORIAL HOSPITAL & MEDICAL CENTER DIRECTOR CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION IOd. INSIDE CITY Allegany 1 YES 2X NO Oldtown FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE Route 1 Box 433 USA 21555 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 YES 2 NO Specify: BY white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emmett Thompson BE Blossom (Baker) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Richard H. Fort 6716 Mill Creek Drive: Zuni VA 20e. METHOD OF DISPOSITION

1X Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Donetion 5 C Other (Specify) Washington Cem. 01 01/31Adelphi, MD George 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scarpelli Funeral Home Cumberland, MD 21502 23. PART I Enter the diseases, or complications that caused the decade ahock, or heart fellure. List only one cause on each line. Approximate Interval Between and Death IMMEDIATE CAUSE (Finel disease or condition SIN resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in deeth) LAST 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO

| RT I | I. Oth | er al | gnifi | cant | con | ditio | na c | cont | ribut | ing | to | deeth | but | not | resui | ting | in th | 10 (| ınder | lying | ce | use | given | in Pa | rt i. | T |
|------|--------|-------|-------|------|-----|-------|------|------|-------|-----|----|-------|-----|-----|-------|------|-------|------|-------|-------|----|-----|-------|-------|-------|---|
| | _ | | | | | | | | | | _ | | | | | | | | | | | | | | - | |
| DID | TOE | BAC | СО | USE | CC | DNI | RII | BUT | ET | 0 0 | A | USE | OF | DE | ATH | YI | ES | | NC | | (| UN | CERT | AIN | A | |

COMPLETION OF CAUSE 1 TYES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Train State)

| DID TOBACCO USE CONTI | RIBUTE TO CAUSE OF DEA | TH YES | NO UNCERTAI | N [Z] | | | | | | | | |
|---|---|-------------------------------------|---------------------------------|----------------------------------|--|--|--|--|--|--|--|--|
| 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 | □ DOA 4 □ Nu | R: rsing Home 5 🗌 Residence | 8 Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DEŞCRIBE HOW INJURY OCCURED | | | | | | | | |

28a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify)

29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.

| one) 2 DEDICAL EXAMINER: On the basis of exemination end/or investigation, in | my opinion, death occured at the time, data and | place, and due to the cause(a) and manner ee stated |
|---|---|---|
| 296. SIGNATURE AND TITLE OF GERTIFIED | 29c. LICENSE NUMBER D 16041 | CALL ALL 3 1996 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

TERRY WILLIAMS M.D., MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERL MD

31. DATE FILED (Month, Day, Year)

JAN 31 1996 REGISTRAR'S SIGNATURE

8 Could not be

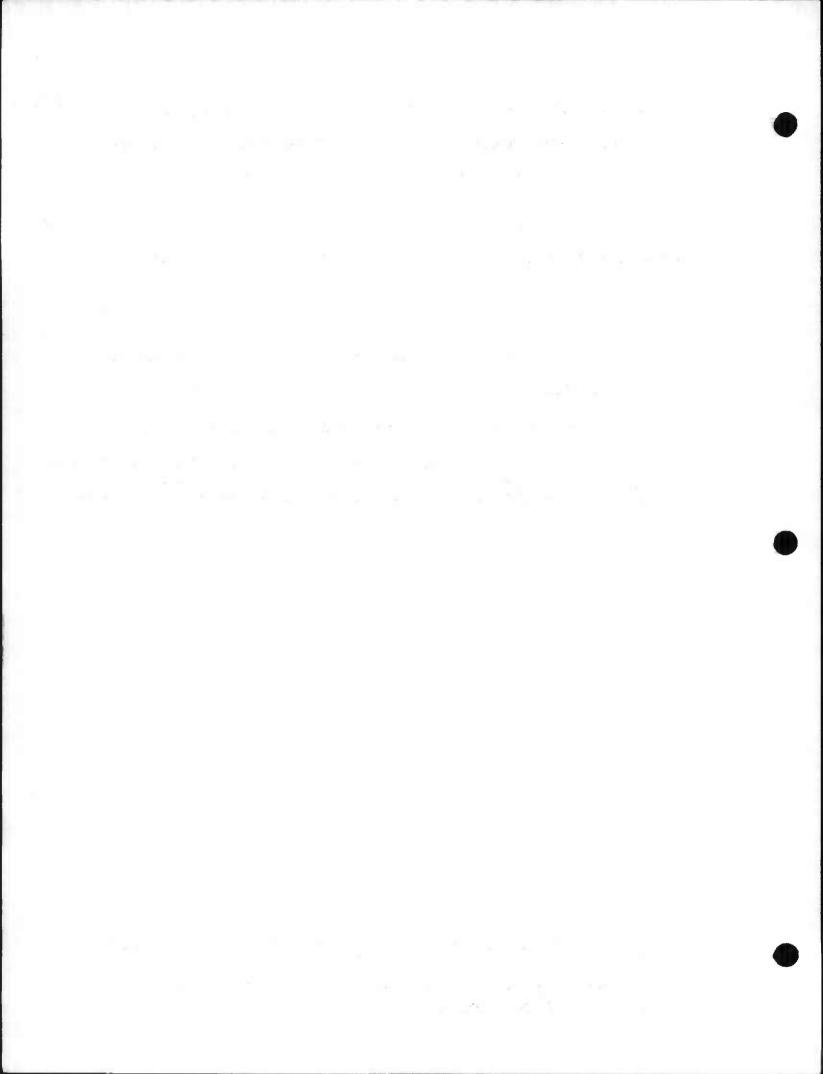
9 11.53

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03707

| | | | | | | Certificate | of Death | R | leg. No. | | 0070. |
|--------------------|---|----------------|---|--|----------------------|--|--|-------------------------|-----------------|------------|--|
| | Discolo | | 1. Decedant's Name (First, Middla, L. | | | | | 2. Data of Dea Month | | Voor | 3. Tima of Death |
| u | Physic /Medi | | Evelyn Eli | zabeth | tran | ce | | JAN | 25 | 96 | 12 Pu |
| | Exami | | 4e. Fecllity Neme [If not institution, gi | va straet end number) | | | 4b. City, Town, or | | 4c. County | of Death | |
| | | | Washington Cou | nty Hospit | al | | Hagersto | own | Wash | ingto | n |
| Т | Funeral | Г | | | ja (In yrs. last bir | thday) If Undar 1 Y | aar If Undar 24 Hrs ays Hours Min. | | | | pleca (Stata or Foraign |
| | Director | | 214-09-3245 | 1□ M 2√F | 79 | Yrs. | ayo Houro Ivian. | July 18 | 1916 | Mary | |
| | pu . | | Usuel Residance of Decedant 10a. Stata 10b. County | | 10c. City, Tow | n os Location | <u>_</u> | | | | 404 1-14-00-41-0 |
| | sho | 2 | | | | | | | | | 10d. Inside City Limits 1 ☐ Yas 2 ☑ No |
| | he N | Director | Maryland Washin | gton | Ha | agerstown | | | | | 41 |
| | No. | ä | | | | 10f. Zlp Co | | 1 | Og. Citizen of | | atry? |
| | e 23 | Funeral | 17834 Virginia A | 12. Was Decedent | Ever le II C | | 740 | Inneity Vee or No | U.S.A | - | can Indian, |
| _ | iter d | 'n | 11. Marital Status 1 ☐ Nevar Merriad 2 ☐ Married | Armed Forcas? | | If Yes, specify | of Hispanic Orlgin? (S Cuben, Maxican, Puer | to Rican, atc.) | | ck, Whita, | |
| 20 | Irs af | by F | 3 Novar Memad 2 Married | If Yas, Giva Yaar or Datas: | 40 | 1□ Yas 2X | No Specify: | | Specify | | |
| 21215-0020 | 2 hou | Pa | 15. Dacedant's E | ducation | 16a. | Decedent's Usual O | | | 16b. Kind of B | Whit | |
| 215 | n n | Completed | (Specify only highast gr Elementary/Secondery (0-12) | | = ,) | (Giva kind of work d lifa. DO NOT usa n | ona during most of wo etired) | rking | | | |
| 21 | d with | E | 8 | College (1-4or 5 | 0+) | Waitress | | | Restau | irant | |
| b | office of the | Bec | 17. Fathar's Nema (First, Middla, Las | () | | | 18. Mother's Na | ma (First, Middla, | | | |
| lar | Aenta Aenta rked rked | TOE | Burnze W. Compho | r | | | Sall | ye E. Wa | 11ace | | |
| any | shot and N | | 19e. Informant's Name/Ralationship | (Type, Print) | 19b | . Mailing Address (Si | raet and Number or R | - | | State, Zi | Coda) |
| Σ | alth a | | Ammon Espenship | (Nephew) | 155 | East 7th | Ave. Tra | ppe, Pa. | 19426 | | |
| ore | of He isem | | 20a. Mathod of Disposition | | 20b. Placa of | Disposition (Nama ory, cramatory or othar | of | * * | 20c. Location | City or To | own, Stata |
| Ĕ | Pege mr. m | | 1 Paurial 2 □ Cramation 3 C 4 □ Donation 5 □ Other (Space | | | Haven Ceme | | -96 H | agersto | wn. | Maryland |
| altimore, Maryland | permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is married other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in Medical Examiner must be notified at once. | | 21. Signeture of Eunecal Sarvica Lica | nsee 00 | - | | ddrass of Facility Mi | | | | in i j i i i i i i i i i i i i i i i i i |
| m | 88E 88 | | Scott | MILL | nniet | | ilson Blvd | | | | 1740 |
| | | | 23a. Part1. Entar tha disaasa, or con | aplications that couse | tha daath. Do r | | | | | | Approximata |
| V. | Physician | | shock, or heart failura. List only | one cause on eech II | na. | | | | | 1 | Intarval Batween Onset end Deeth |
| 4 | /Medical | | Immediata Causa (Finel diseese or condition | Auti | Sun | a verita | inda to | duca | Mia | | |
| В | Examiner | | resulting in death) | a. // | Due to (or as a | consequanca of): | rauce 14 | Jugea | 7,00. | | |
| | 70 Æ | Examiner | | . DOS | sible | iunoras | icular ta diul da | mase | pi- | | |
| | sath certificeta be executed ettending physician end for usa es the buriel-transit | cam | Sequantially list conditions, | 0. | Dua to (or as a | consaguanca of): | | | | 1 | |
| Š, | se exe | E E | Sequantially list conditions, if any, laading to immadiete cause. Enter Undarlying Causa (Disaese or Injury | | | | | | | | |
| 68760, | ohysi the t | edicai | that initiated events resulting in daath) Last | 0. | Dua to (or as e o | consequence of): | | | | | |
| 9 xo | ding g | ≥ I | | d | | | | | | | |
| Bo | es thet tha death cogned by the ettend be detached for us | Physician/ | | | | | | | | | |
| o. | the de | ysic | Pert II. Other significant conditions | | , | tha undarlying caus | a givan In Part I. | , 0 | . / | | o the cause of death? |
| م | ed by detac | P . | Haute Reno | Il fail | ure, | Hair | te Gra | stack 10 Y | 08 205 No | 3 □ Pro | bably 4 Unknown |
| ds, | The law requires that the death ce ata has been signed by the ettendi page 2 should be detached for uss | d by | | 1 ./ | . / | | | 24a. Was a | in autonsv | 24b. W | /ere autopsy findings |
| 00 | v raquire been sig should t | lete | Vasudar Hcci | dent c | hrome | c 06571 | uctive | perfor | | CC | veilabla prior to empletion of causa |
| Re | has ge 2 | Completed | 0 / | 2. | | | | | 1 | | death? |
| g | | | rumonary " | 15845E | | | | 1 Y | | 11 | ☐ Yes 2☐ No |
| Vital Record | ysician: The la s certificata ha director, page | Be c | 25. Was case rafarrad to medical axaminer? | Hospital: | | | Othor | ath (Chack only or | | | |
| Division of | Attending Physician: or deeth. ector: After this certific: by the funeral director, | : To | 1 ☐ Yas 2 € No 27. Manner of Deeth | 28a. Data of Inju | | | 4 Li Nursing r | fome 5 ☐ Rasida | | | (y) |
| o | ding in. | tlor | Natural 5 Pending 2 Accidant investigation | (Month, Da | | njury M | Injury et Work? 1 ☐ Yas 2 ☐ No | | | .06 | |
| S | or Attendation of Director: | fica | 3 ☐ Suicida 6 ☐ Could not t | OB Diana of Inc | urv - At home, fa | rm, straat, factory, of | | 28f. Location (S | traat and Numi | ber or Run | al Routa Number, |
| 2 | メモキロ | Certification: | 4 Homicide | building, af | | ,,,, | | City or Tow | n, Stata) | | |
| | spita nours neral | | 29a. Certifier Certifying Pl | nyalcian: To the best | of my knowledge | , deeth occurrad at th | na time, data and place | a, and dua to tha c | ausa(s) and ma | annar as s | stated. |
| | • Ho • Ful • Ful | edical | (Check only 2 Medicat Example) | miner: On the basis of and mannar sta | axaminetion and | d/or invastigation, in | my opinion, daath occu | urrad at tha tima, d | lata and placa, | and dua to | o the causa(s) |
| | To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral | Me | 29b. Signatura and titla of certifiar | / | | 29c. Li | cansa numbar | 2 | 9d. Date signa | id (Month, | Day, Year) |
| | | | Main E. M. | onen ik | 5). | D | 23815 | | 1/2 | 5/9 | 6 |
| | | | 30. Nama and address of person who | completed cause of d | leeth (Itam 23a) | | | | / | 1 | |
| | | | Mary E. Money, M | | | | , Hagersto | wn, Md. | 21740 | | |
| | Sta | te | 31. Data filed (Month, Day, Year) | The last last | 's Signature | | | | | | |
| | Registr | _ | JAN 2 9 1996 A | PA, (Utantageral) | | | | | | | |

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Jan Fletcher 1996 ELEANOR 9:18PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Memorial Hospital 8. Dete of Birth (Month, Dey, Year) 16. 1922 Easton
If Under 1 Year | If Under 24 Hrs. Yalbot Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1 □ M 280 F Deys Hours 218-80-8470 Yrs. 73 Director Md. Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Talbot Md. Cordova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with is neat of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or Items 23a or 30917 Rabbit Hill rd. 21625 U.S.A Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Yeer or Detes: 1 XNever Merried 2 ☐ Married Baltimore, Maryland 21215-0020 Black 1 ☐ Yes 2 25No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 08 none none Department of Health and Mental Hygin Important: If I fem 27 is marked other any injury or other traumatic event, II 2012. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be James Fletcher Alice Skinner 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30917 Rabbit Hill rd.Cordova, Md. 21625 Reid/ sister Marie 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Removel from State John Wesley Ceme. 1/26/96 Chapel/Easton, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Williamson-Fluharty Funeral Service, P.A. 319 E.Dover st. Easton, Md. 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Infervel Between Onset end Deeth **Physician** /Medical Heart Failuro Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or as e consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 Unknown þ Gevere Jayphoscolosis 24b. Were autopsy findings sveliable prior fo completion of cause of deeth? 24a. Wes an eutopsy performed? Completed certificate has b 2 4 NO 1 Tyes 2 TLNO Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Realdence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted. Medical 29a. Certifier To the 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 609-B Dutchmans Lane Easton, Md. 21601 Peter L. Whitesell, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 1996 Julia discolor Rardall Registrar

The state of the s

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | 1. DECEDENT'S NAME (First | , Middle, Lest) | | | | TO/ATE | - 01 | DEA | - | 2. DATE OF DEATH | , <u> </u> | | 3. TIME OF DEATH |
|--|---------------|--|----------------------------------|--|-------------------------------|-------------------|---------------|----------------|------------|-----------|---|--------------|------------|--|
| | | Robert | Barnha | art I | olev | | | | | | MONTH [| AY 1 (| 996 | |
| | | 4. SOCIAL SECURITY NUME | | 5. SEX | | s. last birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | February 7. DATE OF BIRTH | <u> 1 1,</u> | | 2:55 P M PLACE (State or Foreign |
| ъ | | 577-05-6227 | 7 | 1 😡 M 2 🗌 F | 82 | YRS. | MONTHS | DAYS | HOURS | MIN. | Oct. 5,19 | 13 | Count | mington, DC |
| 3 should | | 8a. FACILITY NAME (If not in | | | | | 9b. CITY | , TOWN | OR LOCATIO | ON OF DE | | | NTY OF D | |
| 2.3 | DIRECTOR | Holy Cross | Hospit | al | | | Si | lve | r Spr | ing | | Mo | ntec | omery |
| | 띮 | RESIDENCE OF DEC | 10b. COUNTY | , | | 10c. CIT | Y, TOWN C | OR LOCA | TION | | | | | 10d. INSIDE CITY |
| 28 | 8 | Maryland | Mc | ntgomery | | | | | | | | | | LIMITS? |
| Sermit | | 10e. STREET AND NUMBER | | inegomer y | | | rive | | pring | | | 10g. CIT | IZEN OF V | WNAT COUNTRY? |
| usit s | ER | 318 Branch | Drive | | | | | | 20901 | | | US | | |
| rial-tra | FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEOEN FORCES? 1 | T EVER IN U.S | ARMED | 13. | WAS DEC | ENDENT O | F HISPANI | IC ORIGIN? (Specify Ye | | 14. RACI | E — American Indian, |
| 2 2 | ВУ | 1 Never Married 2 X 3 Widowed 4 Divo | | IF YES, GIVE V | MR OR DATES | ₩ | | | 2 X NO | | , Puerto Ricen, etc.) | | Spec | k, White, atc. |
| 5 should be detached for use as the burlal-transit permit. Pages notified at once. | ا م ا | | EDENT'S EDUC | CATION | 160 | . DECEDENT'S | HOULE | 00/10/7/ | 041 | | T | | | White |
| M USe | COMPLETE | | y highest grade | | | (Give kind of a | work done o | | | g | 18b, KIND OF BU | SINESS/INI | DUSTRY | |
| bed for | [로] | Claimentally/Secondary (o | P-12) | 4 | " | Electr | ical | Eng | ginee | r | D | rivat | | |
| detach once. | Š | 17. FATHER'S NAME (First, M | liddle, Last) | | | | 1041 | 43117 | 1 | | ME (First, Middle, Meider | | .е | |
| 2 To | ш | Clarence We | ber Fo | ley | | | | | L | ucy | Fannie Bl | ount | | |
| 5 should | TO B | 19a. INFORMANT'S NAME (7 | | | | 19b. MAILING | ADORESS | (Street a | | | oute Number, City or Tov | | Code) | |
| page 5 | - | Helen B. Fo | | - | | 318 E | ranc | h Di | rive, | Sil | ver Sprin | g, MD | 20 | 901 |
| oc. pa | | 20a. METHOD OF DISPOSITE | n 3 🗆 Rame | oval from State | 20b. PLA cameter) | CE AND DATE | of DISPOS | ITION (Ne | ame of | | DATE 20c. LC | CATION — | | |
| e funeral director, pli examiner must | | 4 Donation 8 Other 21. SIGNATURE OF FUNERAL | | FNSEE | For | cremetory or o | | | tery | | | ntwo | od, l | MD |
| funeral | | | 10/00 | 1/1/ | */) | | | | | | lins Fune | ral H | omo | Inc |
| the fr | - 9 | | WWW | WULL | oll | | 150 | O 111 | liver | Sity | Rlad W | 247 0 | mar M | D 20901 |
| d in by the or remova medical | | 23. PART I. Enter the di shock, or he | iseases, or c eert feilure. I | omplications that List only one cau | t caused the | deeth. Do r | not enter | the mo | de of dyli | ng, such | as cerdiac or reap | iratory sn | reat, | Approximsta interval Batween |
| filled on. o | | IMMEDIATE CAUSE (Fine) disease or condition Onset and Death | | | | | | | | | | | | |
| cremation. | | resulting in death) | → , | . P5f | IRATI | ON F | NE | MI | NIA | | | | | Tolays |
| ng physician and completely filled in by th giene prior to burial, cremation, or remova other traumatic event, the medical | | | | MA | (OR AS A COI | RIT | F): */ | 1 | | | | | | 1110045 |
| n and com to burial, imatic en | O | Sequentially list conditi if any, leading to immed | lons, | DUE TO | (OR AS A CO | SEQUENCE OF | / U / Y | | | | | | | WEELS |
| prior trau | CAT | cause. Enter UNDERLYI | NG | CEC | AC 1 | ELFO | RAT | 1701 | V | | | | | 240/445 |
| the attending physician Mental Hygiene prior to njury, or other traur | CERTIFICATION | CAUSE (Disease or inju that initiated events | | | | SEQUENCE OF | | | | | | | | 0.0112 |
| F H | ER | resulting in death) LAS | | | | | | | | | | | | |
| signed by the att Health and Menta IWS any Injury, | - 1 | PART II. Other significa | nt condition | s contributing to | deeth but n | ot resulting i | in the un | derlyin | g ceuse g | lven in F | Part i. 24e. WAS AN | AUTOPSY | 24b | WERE AUTOPSY FINDINGS |
| ed by the and any in | EDICAL | CARDIAC | ARK | YYTHUL | 4 | | | | | | PERFO | 15 | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| signed Health a | | | | | | | | | | | II II YES | NO | 1 | OF DEATH? 1 TES 2 NO |
| as been Jept. of 23 sho | 2 | DID TOBACCO U | SE CONTR | RIBUTE TO CA | USE OF D | EATH YE | S 🗆 N | 10 2 | UNC | ERTAIN | | | | 1 123 1 1 100 |
| certificate has been the State Dept. of or item 23 s | SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL | 26. F | LACE OF DEAT | | | | | | | | |
| rtifica he Sta or it | > II | 1 - YES 2 NO | | HOSPITAL: | ER/Outpatian | n 3 □ DOA | OTHER | | e 5 🗆 Res | ildenca 8 | Other (Specify) | | | |
| 2 4 8 | H | 27. MANNER OF BEATH | Pending | 28a. DATE OF (Month, D | | 28b. TIM INJ | E OF URY | 28c. INJ WO | URY AT | | 28d. DEŞCRIBE HOW | NJURY OC | CURED | |
| offer this eath with marked | BY | 2 Accident | investigation | 00 (00 (00 0 | | | М | | YES 2 | - | | | | |
| after d | ED | | Could not be datermined | building, | FINJURY — A atc. (Specify) | 1 home, 1erm, s | street, 1acto | ory, offic | | | 281, LOCATION (Street City or Town, Stete) | and Number | or Rural F | Route Number, |
| DIRECTOR: After the hours after death vitem 28 is mark | | 29a, CERTIFIER | | | | | | - | | | | _ | - | |
| 교 이 = | COMPL | (Check only | | | | | | | | | o the cause(s) and me | | | 3811Um 200 - 11 m |
| TO THE FUNERAL be filed within 72 I | 8 | 29b. SIGNATURE AND TITLE | | 1. On the open of a | commented and | VOF INVESTIGATIO | n, in my o | pinion, a | | | | d dua to 1h | e canse(s |) and manner as stated. |
| Fed filed | BE | CON 18 | VIII | spery of | 160 | | | | 29c. LICE | NSE NUME | BER / C/ | 29d. DAT | E SIGNED | (Month, Day, Ybar) |
| P 2 E | 2 | 30. NAME AND ADDRESS | PERSON WHO | COMPLETED CAUS | E OF DEATH | ITEM 27) /Type | Printi | | レス | 327 | | | 411 | 10 |
| | | Robert, T. Gin | shara | M.D à | 2415 | | POU | 5 / | 20 | #2 | 209 5/11 | SR C | PRIN | 6. MD 2004 |
| | | 31. DATE FILED (Month, Day, | | 39. REGISTRA | R'S SIGNATUR | IE . | - 1 | | - 51 | 11- | 1 1/21 | | | -1, 2001 |
| | | FEB 02 | 1996 | Value d'au | whor ha | rdall | | | | | | | | |
| | | | | | | | | | - | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

03710

| | | | | | | Certificate of | Death | Re | g. No. | 0 00710 |
|------------|--|----------------|---|--|---------------------------------|---|-------------------------------|---|---------------------|--|
| 1 | Physic | ion | 1. Decedent's Nema (First, Middla, L | ast) | | | | 2. Date of Deeth Month | _ | 3. Time of Death |
| 4 | /Medi | | Joseph | Francis | | Flynn | | January | 26,1996 | |
| ر | Exami | | 4e. Fecility Name (If not Institution, ga | ive street end number) | | | 4b. City, Town, or L | ocation of Deeth | 4c. County of I | Deeth |
| | | | Montgomery Gener | al Hospital | | | Olney | | Montgo | mery |
| 9 | Funeral Director | | 5. Sociel Security Numbar 6. 026-09-1136 Usuel Residence of Dacadent | Sex 7. Aga 1 □XM 2 □ F | (In yrs. last bir | thday) If Under 1 Yea Months Days | | 8. Date of Birth (Month, Dey, Sept.12 | Year) 9. | Birthplaca (Stata or Foreign Country) Massachusetts |
| | yland | | 10a. State 10b. County | | 10c. City, Town | n or Location | | | | 10d. Insida City Limits |
| | the Marylan 28a-f show | Director | Maryland Montgo | omery | | dus ex | 29 . | Silver | | 1₺ Yes 2□No |
| | th with | rai Dir | 10e. Straet and Number 3449 S. Leisure | World Blvd. | | 10f. Ztp Code 2090 | 06 | 10 | g. Citizen of Wha | it Country? |
| 21215-0020 | ē 2 2 | by Funeral | 11. Marital Stetus 1 Nevar Married 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Yeer or Detes: | er in U,S. | 13. Wes Decedant of If Yes, apecify Cult | | pecify Yes or No- Pican, etc.) | | American Indian, Whita, atc. 'hite |
| 5-0 | n 72 hours | Be Completed | 15. Decedent's E (Specify only highest gi | Education rada completed) | 18a. | Decedent's Usual Occu | pation | king | 6b. Kind of Busin | ess/Industry |
| 121 | within ene. | npi | Elementery/Secondary (0-12) | College (1-4or 5+) | | (Give kind of work done life. DO NOT use retire | ed) | ang . | | |
| 2 | ygiene ygiene ner the | S | | 4 | St | ate Departm | T | | U.S.Gov | ernment |
| Maryland | s 1 and 2 should be filed within f Health and Mental Hygiene. fem Z7 is marked other than other traumatic event, traumatic | Be | 17. Fether's Neme (First, Middle, Las | t) | | | | a (First, Middla, M | eiden Sumeme) | |
| yia | Men Men | 2 | John T. Flynn | | | | Mary | Kelly | | |
| Jar | 2 sh and is m | | 19e. informant's Neme/Reletionship | (Type, Print) | 19b. | Meiting Address (Stree | at and Number or Ru | rai Route Number, | City or Town, Ste | ite, Zip Code) |
| | 1 end 2 Health em 27 i | | Marcella W. Flyn | nn (wife) | | | | Blvd.,Si | lver Spr | ing, MD.20906 |
| ore | @ D | | 20a. Mathod of Disposition 1 | Demoval from State | 20b. Pieca of cemeter | Disposition (Name of y, crematory or other pla | ace) | Data 2 | Oc. Location - City | y or Town, Stete |
| E | Peges nent of I ant: If ite ury or of | | 4 Donetion 5 Other (Special | | | f Heaven Ce | | in.31,96 | Silver S | pring, Md. |
| Baltimore, | permit. Peges 1 end Department of Health Important: If item 27 any injury or other tr | | 21. Signatu Funerei Service Lice | nsee | 0 | 22. Nama and Addr DeVol Fur | ess of Fecility neral Home | | | - |
| - | | Н | 23s Part Enter the disease or on | Deva | a doub Do | 2222 Wisc | onsin Ave | ., N.W., W | ashingto | n,DC 20007 |
| | Physician /Medical Examiner | | 234 Pen. Enter the disease, or consider. List only Immediate Cause (Finel disease or condition resulting in death) | | | Obsta | | | | Approximate Interval Between Onset and Death |
| ı | | 4 | | Di | ue to (or as e | consequence of): | | | | |
| | cete be executed physician and s the buriel-transit | Examiner | Sequentially list condittons, | b | ue to (or es e d | onsequenca of): | | | | |
| ,09 | be exician a | a E | Sequentially list conditions, if any, leeding to Immadiete cause. Entar Underlying Cause (Diseese or Injury | G | | | | | | |
| Box 68760, | 1 0 a | /Medicai | that initiated events rasulting in daeth) Last | d | ue to (or es a c | onsequence of): | | | | |
| ğ | death ce attendi | iciai | Part II Other elanificant conditions | contribution to death but | | the condendation and a | han to Mark I | DON DIE AND | | |
| P.O. | the the | / Physician/ | Pert II. Other significant conditions Which better | wellit | | Of the | Nen in Pert I. | 1 1 1 | /_ | buts to the causs of death? ☐ Probably 4 ☐ Unknown |
| Records, | w requires that the been signed by the should be detache | Completed by | Jubrilla | tion | | | | 24a. Was an performe | | 4b. Were autopsy findings available prior to completion of causa |
| Re | 4 2 5 | ошо | 0 | | | | | 1 ☐ Yes | 2 No | of death? |
| of Vital | defan: The certificate rector, pag | BeC | 25. Wes case referred to midical | | | | 26 Place of Deal | th (Check only one | | 10 165 2011 |
| > | Physician: this certific | To B | examiner? | Hospitel: 10 Inpatient | 2 ER/Out | patient 3 DOA | har | ome 5 Residen | | Canalful |
| 0 | r this | | 27. Menner of Beeth | 28a. Dete of Injury | 28b T | | | 28d. Describe hov | | Specify) |
| O | dlng Th. | tion | 1 Naturel 5 ☐ Pending 2 ☐ Accidant invastigation | (Month, Day) | (ear) ir | | ork?]Yes 2□No | | | |
| Division | dea ctor | Certification: | 3 ☐ Suicide 6 ☐ Could not t | On Place of Indian | - At home fai | m, atreet, factory, office | | 28f. Location (Stre | et and Number o | or Rural Route Number, |
| S | Olre J in b | ert | 4 Homicide | building, etc. | (Specify) | m, and on, ractory, onloc | | City or Town, | | |
| | To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate his completely filled in by the funeral director, page | edicai C | 29a. Cartifier 1 Certifying Pl | nysician: To the best of r miner: On the basis of ea | ny knowledge, kaminetion end | deeth occurred at the t | ime, dete and place, | end due to the cau | use(s) and manne | or as stated. |
| | the I hin 2 the I | Med | 7 // | and manner state | d. | | | | | |
| | Vit To | | 29b. Signature and tolli of partifler | The | W | 29c. Licen | SP45 | 7 5 | d. Dete signed (M | 126, 1996 |
| _ | | | 30. Name and address of berson who | ans ! | Bul 1 | RINGE | PHILIP | DN, O | LNEY | My 20837 |
| | Sta Registr | | 31. Dete filed (Month, Dey, Year) JAN 3 0 1 | 996 32. Pegistrar | Signeture Lucture | ardall | | | | |

Please Type or Print in Black indelible Ink. Assure All Copies Are Land State of Maryland / Department of Health and Mental Hygiene 9.6.

| _ | | | Certificate of De | eath | Reg. | | 03711 | | | | | |
|-----------------|--|-------------------------------|--|--|---|--------------------------------------|---|------------------------|----------------|--------|--|--|
| ı | Physic | | Decedent's Name (First, Middle, Last) JOHN Edward FLYNN FLYNN | | Dete of Deeth Month ANUARY 2 | Pay 199 | 3. Time of Deet | h | | | | |
| ۱ | /Medi Examii | | 4e. Facility Neme (If not institution, give street end number) 4b. | 4b. City, Town, or Location | | 4c. County of Deeth St. Mary's | | | | | | |
| | Funeral Director | | 473-44-5650 XXM 2□ F 75 Yrs. Months Deys | Hours Min. AL | Dete of Birth (Month, Day Ye gust 26, | 1920 | D. Birthplece (State or Ford Country) Minnesota | eign | | | | |
| 020 | Meryland a-f show | tor | Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Maryland Prince George's Beltsville | | | | 10d. Inside City Lin | | | | | |
| | th with the 23a or 28 | Funeral Director | 10e. Street end Number 10f. Zip Code 20705 | | _ | Citizen of Wh | | | | | | |
| | be filed within 72 hours after deeth with the Meryland lel Hygiene. d other than "natural", or items 23a or 28e-f show event, the Medical Exeminer must be notified at | Be Completed by | 11. Maritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever In U.S. Amped Forces? AMY es 2 No If Yes, specify Cuben, 1 Yes, Sive Year or Detes: WWII | | Yes or No- an, etc.) | | American Indien, White, etc. White | | | | | |
| 21215-0020 | vithin 72 ho | | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 College (1-for 5+) College (1-f | | | Kind of Busin | ness/Industry | | | | | |
| | I and 2 should lealth and Men m 27 la marke her traumatic | | Be | 17. Father's Neme (First, Middle, Last) | 8. Mother's Neme (Fi | | | | | | | |
| Maryland | | To | 19e. Informent's Neme/Reletionship (Type, Print) Patrick J. Flynn (son) 19b. Meiling Address (Street end same as #10 | d Number or Rural Ro | oute Number, Cli | ty or Town, St | ate, Zip Code) | | | | | |
| Baltimore, | | | 20e. Method of Disposition 1XX urial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Arlington National Cemeters | | | | ty or Town, Stete Virginia | | | | | |
| Balt | pemit. Pages 'Department of Finportant: If ite any Injury or of once. | | 21. Signature of Funeral Service Licenses 22. Name and Address Donald V. Borro 4400 Powder Mi | of Fecility Jwardt Funera 111 Road Belt | al Home, I sville, N | P.A. Yaryland | 20705 | | | | | |
| 68760, | Physician parameter per assented as the conficuency of the confidence of the confide | by Physician/Medical Examiner | Immediate Cause (Fine) disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest e. Turning al Concern Concerns and Concerns | inoma | 3 The | glam. | Onset and Death | | | | | |
| .O. Box | that the death ed by the atte detached for | | by | by | by | by | Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given | in Pert I. | 23b. Did tobec | | ibuts to the cause of dea | |
| cords, P. | The law requires that the death cert ale has been signed by the attendin page 2 should be detached for use | | | | | | Failme to thrive | | 24e. Wes an eu | rtopsy | 24b. Were autopsy finding available prior to completion of cause | |
| of Vital Record | | Completed | , | | 1 ☐ Yes | 2 No | of death? | | | | | |
| Vita | Physician: The this certificate rail director, pag | o Be | examiner? Hospital: | 26. Piece of Deeth (Ci | | - Clay | | | | | | |
| | nding Physath. r: After this ie funeral di | Certification: To | 27. Menne of Deeth 1 | 4 LI Nursing Home | Describe how in | | | | | | | |
| Division | To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral | | Certific | 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | 28f. | Location (Street City or Town, St | end Number ete) | or Rural Route Number, | | | | |
| | he Hospl in 24 hou he Funer pletely fil | edical | 29e. Certifier (Check only one) 13 Certifying Physician: To the best of my knowledge, deeth occurred et the time, 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opini end menner steled. | dete end piece, and ion, deeth occurred a | due to the ceuse t the time, dete | e(s) end mann end piece, sno | er as stated. d due to the cause(s) | | | | | |
| | Tot Tot | Σ | 29b. Signeture end title of certifier 12y H. Bung, m.D. 29c. License no | | | | Month, Dey, Year) | | | | | |
| _ | | | ily H. Bunk, m.D. D: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROY 1 1465 Great Mills Rd., Lexing 7 | H. Bunale | K, n. | ים עו | 0653 | | | | | |
| | Sta Registr | te | 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture JAN 3 0 1996 Falls Dawelson-Randell | | | | | | | | | |

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Lecible

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month Physician WILLIAM FIRMIN JANUARY 30. 1995 1:30PM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Cheverly Prince Georges Hospital Center Prince Georges Months Deys Hours Min. No. 18, 1918 6. Sex 10 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Funeral Director 579-07-8476 Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Prince Georges 1 ☐ Yes XX No Hyattsville Director 10f. Zip Code 10g. Citizen of What Country? 4100 Queensbury Road 20782 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: specity: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Mail carrier U.S.Postal Service 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be John Clingan Firmin Elsie Mae Monroe 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Firmin 6708 conway Ave. Takoma Park, MD 20912 20e. Method of Disposition
1 □ Burial 2 2 Cremation 3 □ Removal from Stete 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete Metropolitian Crematory Jan. 31,1996 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home, Inc. 21-Signature of Funerel Service Licenses 254 Carroll St. NW Washington, DC 20012 23e. Pert1. Enter the disease, or complication. That caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceut on each line. Approximate interval Between Onset end Death Physician /Medical Immediete Cause (Finet Myocardial Infarction Zweeks diseese or condition resulting in death) Examiner Artemosclerotic Candiovascular Diseade Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es a consequence of): and Box 68760, attending physician for use as the buna Physician/Medical Due to (or es e consequence of) P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Comparting heart failure, anoxic encephalopathy, been signed by should be detac 1 ☐ Yee 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings aveitable prior to completion of cause of deeth? Completed 24e. Was an autopsy performed? failune 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitat: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursting Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending a 24 hours after death.

Funeral Director: After the function of the function NIA 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end manner stetled. within 2 To the f 4 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Bullen Dechil JANUARY 31 1996 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Paul A. DeVore, M.D. 4203 Queensbury Rd. Hyattsville, MD 20781 31. Dete fited (Month, Day, Year) -32. Registrar's Signature

DHMH 16 Ray 6/95

State

Registrar

1996

FEB 01

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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| | | | | | , | Cer | tificate of | | Re | ig. No. | , 0 0 | 0110 |
|------------|---|---|---|--|-----------------------------------|-----------|-----------------------------------|--|------------------------------------|-----------------|------------------------------------|--|
| П | | | 1. Decedent'a Nama (First, Middle, | Last) | | | | 11 | 2. Date of Death Month | Day | Year 3. | te) 20748 Stata VA Home VA Proximate stand Death 15/96 15/9 |
| | Physici /Medi | | VIRGINI | A | FLETC | HEF | 2 | | Januar | | | 12:55p |
| Ďε | Examir | | Ab Color 3 | | | | 4b. City, Town, or L | | 4c. County | | | |
| 1 | | | Prince George | s General | Hospi | tal | | Chever | rlv | Prin | ice Ge | orges |
| Т | Funeral | П | | Sex 7. Ag | a (In yrs. last bir | | If Undar 1 Yaar Months Days | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, | | | |
| | Director | | 578-07-7927 | 1□M 2⊠F 9 | 7 | Yrs. | Months Days | Hours Ivin. | Nov.11 | ,1898 | Vira | inia |
| | D | | Usual Residence of Dacedent | | | | | | | | | |
| | how the | | 10a. State 10b. County | | 10c. City, Tow | | | | | | | |
| | o M | cto | MD Pr. G | eo. | | Cam | p Spri | ngs | | | | X Yes 2 No |
| | # 12 # | Sire. | 10e. Street and Number | | | | 10f. Zip Coda | | 10 | g. Citizan of V | What Country? | |
| | 23a | a | 4500 Henderso | n Road | | | 207 | 748 | | U.S | A. | |
| | 89 E | Funeral Director | 11. Marital Status | 12. Wes Decedent Armed Forces? | Ever in U,S. | 13. W | as Decedent of | Hispanic Orlgin? (Sp ban, Mexican, Puerto | ecify Yes or No- | | e - Amarican Ir ck, White, etc. | ndian, |
| 020 | 72 hours after deeth with the Maryland natural', or ferms 23a or 28a-f show first Examine must be mother at | by Fu | 1 Never Married 2 Married 3 ₩ Widowed 4 Divorced | | | | ☐ Yes 2€ No | | , , , , , , , | Specify | | ck |
| 21215-0020 | d within 72 hours aft plene. r than "natural", or tre Medical Exert | | 15. Decedent'a | Education | 16a. | Decede | ent'a Usual Occu | pation | . 1 | 16b. Kind of Ba | vsiness/industr | y |
| 215 | within 7 ene. then "n | Completed | (Specify only highest (Elementary/Secondary (0-12) | rade completed) College (1-4or : | 54) | (Give k | ind of work done O NOT use retire | ipation a during most of work ad) | ing | | | |
| 21 | d withi | E | 10th | College (1-40) | , , , | (| Clerk | | | G.S. | Α. | |
| | be filed vital Hygierd other trees. | Be | 17. Father'a Name (First, Middla, La | st) | | | | 18. Mother's Nam | e (First, Middla, N | laidan Suman | na) | |
| /a | should be nd Menta marked maric ev | ToE | Luther Marti | n. | | | | Ella | Finley | | | |
| Maryland | " = _ 3 | - | 19a. Informant's Name/Relationship | (Type, Print) | 19b | . Malling | Address (Stree | at and Number or Rui | - wh | | Stata, Zip Coo | da) |
| | rtr. | | James Finley | (Cousin) | 4 | 1500 | Hende | erson Rd | ., Camp | Spri | ng. MI | 20748 |
| re | item 2 other | | 20a. Method of Disposition | | 20b. Place o | Dispos | ition (Name of atory or other ple | | | | City or Town, | |
| E | Pege ent or: If ry or | | 4 Donution 5 Other (Spe | ☐Removal from Stata | | | | ery 1 | /27 | Winch | ester, | VA |
| Baltimore, | permit. Peges in Department of Historiant: If ite any injury or of once. | | 21. Signature of Funeral Service Lic | | | 22. | Name and Addr | ess of Facility Ca | artwria | ht Fu | neral | Home |
| Ö | Deg and Se | | 1 Inuce | e at | weigh | 23 | 32 East | Fairfa | k Ln, W | inche | ster, | VA |
| | | | 23a. Parti. Enter the disaasa, or co shock, or heart lailure. List on | mplications that caused by one causa on each li | the death. Do | not ente | r the mode of dy | ing, such as cardiac | or respiratory erre | eat, | Apr | proximate erval Between |
| | Physician | | | | | | | | | | On | set and Death |
| 1 | /Medical Examiner | | Immediate Cause (Final disaasa or condition resulting in death) a. SEPTICEMIA //15/96 | | | | | | | | | 15796 |
| | LABITITIE | L | resulting in death) | | Que to (or es e | consequ | vence of): | | | | / | 11, |
| | Sit 9d | ine | | Ne | 14 C | tro | itro | n | | | 1/ | 15/96 |
| | ifficete be executed g physician end as the buriel-transit | Examiner | Sequentially list conditions, | 1-1 | Due to (br as a | consequ | vence of): | • | | | / | 1/1/00 |
| 60, | be ey ician burie | 品田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田 | Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Cause (Disease Or Injury Cause (Disease Or Injury Cause (Disease Or Injury Cause (Disease Or Injury Cause (Disease Or Injury Cause (Disease Or Injury Cause (Disease Or Injury Cause (Disease (Disease Or Injury Cause (Disease (Disease Or Injury Cause (Disease | | | | | | | | | 15/96 |
| 68760, | cete chysi the | edical | that initiated events resulting in death) Last Dua to (or as a consequence of): | | | | | | | | | / |
| | E 0 6 | | | d | | | | | | | 9 2 | |
| Box | the ett | Physician/M | | | | | | | | | | |
| o | that the de led by the a detached | ysic | Part II. Other significant conditions | contributing to death b | ut not resulting in | n the un | derlying cause g | iven In Part I. | 23b. Dld to | bacco uae co | | cause of death? |
| P.0 | that the ed by detac | | 1) ye bh | ag19, | | | | | 1 □ Ye | 2 200 | 3 Probabl | y 4 Unknown |
| S | v requires t been signe should be | i by | 2 | 1. | - | | | | 04 144 | - 67056 | Odb Wass | utana. Ila dia a |
| 0 | requ | Completed | Denier | 1119 | | | | | 24a. Wes ar perform | ned? | availab | ole prior to |
| Records, | e law has b | ldu | | | | | | | | | of deat | h? |
| <u></u> | | Co | | | | | | | 1□ Ye | s 2 No | 1 ☐ Ya | s 2□ No |
| Vital | Physician: The this certificate ral director, pag | Be | 25. Was cese referred to medical examiner? | | | | | | th (Check only on | 9) | | |
| of | Physic this or | 2 | 1 Yes 25 No | Hospitel: | int 2□ER/Ou | utpatient | 3□ DOA O | ther: 4 Nursing Ho | oma 5 Reside | nce 6 Oth | er (Specify) | |
| n | ding Ph h. After th funeral | :uc | 27. Manner of Deeth ↑ Neturel 5 □ Pending | 28a. Dete of Inju (Month, Da | ry 28b. | Time ol | 28c. Inju | ury at ork? | 28d. Describe ho | w Injury occur | red | |
| 0 | Attanding or death. ector: After by the fune | ath | | | | | M 1 | Yes 2□No | | | | |
| Division | r Att | t# | 3 Suicide 6 Could not determine | d Zoe. Place of Inj | ury - At home, fa | ırm, stre | et, lactory, office | • | 28f. Location (Sti City or Town | | oer or Rural Ro | ute Number, |
| | tat on ris aft | Certification: | | | (, | | | | | | | |
| | To the Hospitat or Attandii within 24 hours after death. To the Funeral Director: A completely filled in by the fu | edical | 29a. Certifier Certifying I | Physician: To the best | of my knowledge exemination en | death | occurred at the t | lme, date and place, opinion, deeth occur | and due to the ce | use(s) and ma | anner as atated | i. cause(a) |
| | the the the the the the the the the the | Med | 000 | and manner sta | ated. | | one bless | | Tax | nd Data aidus | d Manth I Day | Vanal |
| | Tol | - | 295 Signature and title of ceatifier | Mari | ta n | , 7 | _ | 2 0 1 0 | 2 | o. Data signe | d (Month) Day | , Tear) |
| | | | - Charx | 1 miles | // | لر٠١ |) | 2010 | 0 | AN Z | 77 | 6 |
| | | | 30. Name and address of person wh | | | | - | | | / | 1 | |
| | | | Rakesh Arora | • | | all | ant Fo | x, Bowie | , MD | 20715 | | |
| | Sta Begistr | | 31. Dete liled (Month, Day, Year) | | ar's Signature | 0 . | | | | | | |
| Cit | Registr | | JAN 31 | 1996 Jillia | Davidson A | arda | 4 | | | | | |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Yeer Phyllis Ann Frazier Jan. 24, 1996 5:10 p. /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Hyattsville Manor Nursing Home Hyattsville Prince Georges If Under 1 Year If Under 24 Hrs. Months Deya Houra Min. Min. July 28, 1955 5. Sociei Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Country) Maryland 215-66-5269 40 Yrs. Director Usual Realdence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnaide City Limits tall Hygiene.

do other than *natural; or items 23a or 28a-f show event, the Medical Examiner must be notified at 28a-f ahow MD Montgomery Silver Spring 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10400 New Hampshire Ave., #104 20905 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yea or No-if Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1X Yea 2 □ No If Yes, Give Year or Detes: 1 Never Merried 2 ☐ Married Maryland 21215-0020 1 Yea 2 No Specify: à Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 11th College (1-4or 5+) U.S. Army Reserve U.S. Army permit. Peges 1 and 2 should be file Department of Health and Mental Hy important: If Hem 27 Is marked other any Injury or other treumatic event once. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Leo Frazier Phyllis Taylor 2 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code 2 0 7 8 2 19e. fnforment's Name/Relationship (Type, Print) Leo Frazier (Father) 6700 Belcrest Rd, #822, Hyattsville, MD Baltimore. 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Desuriai 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Emory Grove Cemetery 1/30 Gaithersburg, MD 21 Signature of Funeral Service Liceosee 22. Neme end Address of Fecility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 231 Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Hospital or Attending Physician: The law requires that the death certificets be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to for as a consequence of Box 68760, Physician/Medicai Due to (or as a consequence of): P.O. been signed by the a should be dateched Part II. Other significant conditions contributing to de 23b. Did tobacco use contribute to the cause of death? eath but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy completion of cause of death? 1 Yes 2 Dk 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 20 No this 27. Menper of Deeth 28a. Date of Injury (Month, Dey Yeer) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No daath. investigation 2 Accident within 24 hours after dasti To the Funeral Director: 3 Suicide 6 Could not be 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide 29a. Certiffei 1💆 Certifying Physicfan: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as steted. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) the 29b. Sign 29d. Date signed (Month, Day, Year) and title of cer 29c. License number 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Dr. Lewis Dennis 6201 Grenbelt Rd., College Park, MD 32. Registrer's Signature 31. Date filed (Month, Day, Year) State

Jalia Studien Randall

JAN 29 1996

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are I acible

State of Maryland / Department of Health and Mental Hygiene 96 03715

| | | | | | | Cer | tificate | of | Death | | | Reg. No. | | | |
|---------------------|---|------------------|--|--|--------------------|---------------|-----------------------------|--------------|--|-----------------|--------------------------------|-----------------------------------|---|---|--|
| | | | 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth | | | | | | | | | | 3. Tima of Death | | |
| | Physici /Medic Examin | | Martha Virginia Gordon | | | | | | Janua | | | | ary Dey 27 1996 9:20a. | | |
| | | | 4e. Fecility Name (If not Institution, give | | | | 4b. City, To | wn, or Lo | cation of Deat | | y of Death | | | | |
| | | | 7450 Emory PLa | Ce | | | | | Hughe | ewi | 110 | ChA | RLES | | |
| Г | Funeral | | 5. Sociel Security Number 6. Sec | ex 7. Age | e (In yrs. last bi | rthday) | If Undar 1 Months D | aar eys | If Under Hours | 24 Hrs. Min. | 8. Dete of Bir 3 Month, Pa | th March | | ce (Stata or Foreign | |
| Ŀ | Director | н | 213-30-4168 | □м 2ХР | 78 | Yrs. | WOILING | oys | Hours | PVIII L. | 3/28/2 | 2917 | Country | "MD | |
| | bu , | | Usuel Rasidence of Decedent | | 10- 07- T | | | | | | | | | | |
| | e Maryla 3e-f shov | ctor | MD 10b. County Charle | es | Hughe | svi | ille | | | | | | 10d | I. Inside City Limits 1 ☐ Yas 2 No | |
| | 23a or 21 | Funeral Director | 7450 Emory Plac | ce | | | 10f. Zip Co | 63 | 37 | | | 10g. Citizen of U.S. | Whet Country S.A. | n | |
| 020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is married other than "naturer", or items 23a or 28a-f show samp fairprot or other traumetic event, the Medical Examiner must be notified at once. | þ | 11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yas ② 2 2 N If Yes, Give Year or Detes: | | H | Vas Deceden Yas, specify | Cubi | lispenic Ori an, Mexica Specify: | n, Puerto I | cify Yas or No Rican, atc.) | | ce - Amarican ick, White, etc by: White | | |
| Ŏ | 2 ho | P | 15. Decedant's Ed | | 16a | . Deced | ent's Usuel C | ccup | ation | | | 16b. Kind ot B | usiness/Indu | stry | |
| 215 | hin 7 | ple | (Specify only highest grada complated) (Give kind of work done during most of working life. DO NOT use retired) [Index of the property (0-12) College (1-4or 5+) | | | | | | | | | | | | |
| 7 | d wit | E | 12 | College (1-4or 5- | T) | | Nurse | 3 | | | | Nι | ursing | g | |
| Maryland 21215-0020 | id be file lental Hy ked othe ic event | To Be Completed | 17. Father's Neme (First, Middle, Last) Robert Plummer | | s | | | | | | | Maidan Sumar Tucker | | bons | |
| ary | shou and M | - | 19e. informant's Neme/Relationship (7 | Type, Print) | 198 | . Meilin | g Address (S | treet | and Numb | er or Rura | l Route Numb | er, City or Town | , State, Zip C | ode) | |
| Σ | alth a | | Luckett W. Emo | ry,Jr. | 74 | 50 | Emory | · | Place | Hu | ghesvi | lle,MI | 206: | 37 | |
| Se. | of He other | | 20a. Method of Disposition | | 20b. Pleca o | f Dispos | sition (Name | of | | | Date | 20c. Location | - City or Town | n, Stete | |
| Ĕ | Pages nent of I ant: If Its ury or o | | 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify | | Metro | pol | itan | Cı | čem. | 1/ | 29/96 | Alexa | ndria | , VA | |
| Baltimore, | permit. Departm Importa any Inju | | 21. Signeture of Funerel Service Licen: | | MOO945 | AR | | '-I | ECHOI | LS F | | L HOME | | | |
| | | Н | 23a. Part1. Enter the disaese, or comp | aug | | Ρ, | O. Bo | X | 567 | LaP | lata,N | ID 2064 | | | |
| | Dhusisian | | shock, or heart tailure. List only | ona cause on each line | 6. | not ente | i the mode o | i uyii | ig, such as | Cardiec o | r respiratory a | rrest, | in | pproximate nterval Between Inset and Deeth | |
| | Physician /Medicai | | Immediate Cause (Final | Comob | 1 57- | | .] 7 | _ | | . 4. | | | | | |
| | Examiner | | diseesa or condition Cerebral Vascula resulting in deeth) | | | | | | cider | ıt | | | | | |
| | | ē | Due to (or as a consequence of): | | | | | | | | | | | | |
| | uted ansit | Examiner | b. Due to (or es a consequence of): | | | | | | | | <u> </u> | | | | |
| , | n and faller | Exa | Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying | · | Due to (or es a | consequ | Jence ot): | 39 01): | | | | | | | |
| 68760, | e be | edicai | Cause (Disaase or injury that initiated events | 0000000 | ionon off: | | | | | | | | | | |
| × | eeth certificate be executed ettending physician and for use as the burial-transit | Ž d | | | | | | | | | | | | | |
|). Bo | that the deeth cered by the ettendin | Physician | Part ii. Other significant conditions co | ontributing to death bu | it not resulting i | n tha un | darlying caus | e giv | en In Part i | | 23b. Dld | tobacco use co | entribute to th | he cause of death? | |
| 0 | hat the ed by th detech | | | Ť | | | | | | | | Yes 2□No | | bly 4 Unknown | |
| Hecords, | requires been sign should be | Completed by | | | | | | | | | 24e. Was | an autopsy | evaile | a autopsy tindings able prior to pletion of cause ath? | |
| | The law te hes vage 2 | mo: | | | | | | | | | 10 | Yes 2 No | 101 | res 2□ No | |
| <u> </u> | | Be C | 25. Was case referred to medical | | | | | | 26. Piece | of Death | (Check only o | one) | | | |
| > | 5 00 | ToE | examiner? | Hospitei: 1 ☐ inpatier | nt 2 ER/O | utpatient | 3□ DOA | Oth | or | | 1 | dance 8 Ott | ner (Specify) | | |
| ouo | 문 문 등 | | 27. Manner of Death Neturel 5 Pending Investigation | 28a. Dete of Injury (Month, Day | y. 28b. | Time of njury | | Injur Wor | | 2 | | now injury occur | | | |
| Division of Vital | or Attending effer death. Director: After in by the fune | Certification: | 2 Accident investigation M 1 1 1 1 1 1 1 1 1 | | | | | | | | ber or Rural R | Route Number, | | | |
| | Hospita 4 hours Funeral tely filled | edical C | 29a. Certifier (Check only one) 2 Medicai Exam | vsician: To the best of iner: On the basis of e | exeminetion en | deeth | occurred et t | ne tin | ne, dete en pinion, dee | d pieca, e | and due to the | ceuse(s) and m date and pieca, | anner as stete and due to th | ed. ne ceuse(s) | |
| | To the within 2 To the comple | Mec | and manner steted. 29c. License number 29d. Data signed (Mon | | | | | | | | id (Month De | IV. Year) | | | |
| | F ≥ F 8 | | 1 you oo | V | MAST | 0 - | | | 352 | | | _ | | | |
| | | | The second | , (, | | ~ | | 0.3 | 112 | | | Januar | . y 29 | , 1996 | |
| | | | 30. Neme end eddress of person who c | | AV005.00 | 1521501 | ALCOUNT . | | | | | | | | |
| 1 | | 40 | Krishan Mathui 31. Date filed (Month, Day, Year) | r, MD P.(| D. Box | 27 | 29 La | F | lata | MI. | 2064 | 6 | | | |
| | Sta Registr | | JAN 3 1 19 | 996 | Dhudeo | Res | latt | | | | | | | | |
| | | | | | | | - | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the intending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NII LANT
31. DATE FILED (MONTH, Day, Year)

JAN 3 (

0

MP

32. REGISTRAP'S SIGNATURE
Station de Revolution Ravialle

| 500 | 2222125 07777 | | | | 90 | 03110 | | | | | | |
|--|--|---|---|--|----------------|---|--|--|--|--|--|--|
| 1 - STATE REGISTRAR | STATE OF MARYL | | TE OF HEALTH AND | MENTAL HYGIENI REG. NO. | E | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF OEATH | | | | | | |
| Helen Ce | celia (| orof t | | 1- 28 | - 96 | 0819 | | | | | | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | 7 | NDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | s. BIF | TTHPLACE (State or Foreign untry) | | | | | | |
| 2012010000 | 1 🗆 M 2 💢 F | S YRS. MONT | HS DAYS HOURS MIN. | 4-23-10 | _ | NNSYLVANIA | | | | | | |
| 9a. FACILITY NAME (If not institution, give stre | EATH | 9c. COUNTY OF | | | | | | | | | | |
| Canoll Co. Gen. H | Canoll Co. Gen. Hospital menonithe westminster (and) | | | | | | | | | | | |
| RESIDENCE OF DECEDENT 100. STATE MARYLAND CAR | | 10c. CITY, TOY | VN OR LOCATION | | | 10d. INSIDE CITY | | | | | | |
| MARYLAND CAR | ROLL | WES | TMINSTER | | LIMITS? | | | | | | | |
| | | | 101. ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? | | | | | | |
| 447 E. GREEN ST | To a second seco | | | | | | | | | | | |
| 7 | 12. WAS DECEOENT EVER IN | | 13. WAS DECENDENT OF HISPA | NIC ORIGIN? (Specify Yea | or No- 14, R/ | ACE — American Indian, | | | | | | |
| | FORCES? 1 YES | | If yes, specify Cuban, Maxic | | | leck, White, etc. | | | | | | |
| 3√XWidowed 4 □ Divorced | | | | | WHITE | | | | | | | |
| 15. DECEDENT'S EDUCA (Specify only highest grade of | (TION ompleted) | 16a. DECEDENT'S USUA (Give kind of work of | one during most of working | 16b. KIND OF BUS | HNESS/INOUSTRY | 4 | | | | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | ille. Do NOT use retir SEAMS | | MANITIEZ | MANUFACTURING | | | | | | | |
| Elementary/Secondary (0-12) 1 1 17. FATHER'S NAME (First, Middle, Last) | | DEMIND | | | | NG | | | | | | |
| | Y J. STAUI | | | AME (First, Middle, Maiden | Surname) | | | | | | | |
| HARK 19a. INFORMANT'S NAME (Type/Print) | I J. STAUL | | SAR RESS (Street and Number or Rural | AH ELTZ | - 01-1-7-0-11 | | | | | | | |
| MARY G. THOMAS | | | EEPY DELL C | | | | | | | | | |
| | 20h | | | | | | | | | | | |
| XXBurial 2 □ Cremation 3 □ Remove 4 □ Donation 6 □ Other (Specify) | 20c. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Commentary Commen | | | | | | | | | | | |
| | 21 SIGNATINE OF FINERAL SERVICE LICENSES | | | | | | | | | | | |
| 254 E. MAIN ST., WESTMINSTER, I | | | | | | | | | | | | |
| - Mesterny //w | Muzal | | | | | | | | | | | |
| 23. PART t. Enter the diseases, or of shock, or heart failure. L. | ist only one ceuse on e | ech line. | nter the mode of dying, su | ch ss cerdiec or respi | ratory srrest, | Approximats Interval Between Onset and Deat | | | | | | |
| IMMEDIATE CAUSE (Finel | IMMEDIATE CAUSE (Finel | | | | | | | | | | | |
| resulting in death) | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSTITUENCE OF: | | | | Days | | | | | | |
| csuse. Enter UNDERLYING | csuse. Enter UNDERLYING | | | | | | | | | | | |
| CAUSE (Disease or injury that initiated events | CAUSE (Disease or Injury | | | | | | | | | | | |
| resulting in death) LAST | IDDM | | | | | | | | | | | |
| PART II. Other significent conditions | contributing to death h | ust not requising to the | dealt lan access along t | 5-41 2 | | 1 | | | | | | |
| S VAIT II. Ottor agrinicon conditions | Contributing to destit b | or not resulting in th | e underlying ceuse given ii | PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | |
| | t □ YES 2 ☑ NO COMPL OF DEA | | | | | | | | | | | |
| DID TORACCO LISE CONTRIBUTE TO CALISE OF DEATH, MES TIMES AND THE LINES FOR TAIN TO | | | | | | | | | | | | |
| DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Chock only one) | | | | | | | | | | | |
| EXAMINER? | HOSPITAL: | ОТ | HER: | | | | | | | | | |
| 27. MANNER OF OEATH | 1 Inpetient 2 ER/Outp | 28b. TIME OF | Nursing Home 5 Residence 28c. INJURY AT | T | | | | | | | | |
| III 1 NITURII 5 Pending | 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? | | | | | | | | | | | |
| 2 Suitable | 2 Accident investigation 28a PLACF OF IN.HIRY — At home form street factory office. 28a 1 CATION (Single and Management of the Control of t | | | | | | | | | | | |
| U 4 ☐ Homicide determined | building, stc. (Spec | cify) | | City or Town, State) | | | | | | | | |
| 29e. CERTIFIER t CERTIFYING PHYSIC CHECK Only one) 2 MEDICAL EXAMINER | IAN: To the heat of my trans | ladra darth course | the time date and store and d | a to the source! | | | | | | | | |
| (Check only one) 2 MEDICAL EXAMINER | | | the time, data and place, and du my opinion, death occured at th | | | se(s) and manner as stated | | | | | | |
| 20h CICNATURE AND TITLE OF CERTIFIED | 0 | | | | | | | | | | | |
| 2 STATUTE OF CENTIFIED | 296. SIGNATURE AND TITLE OF CERTIFIED 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) NTERNIST 1296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | |
| 30. NAME AND AUDITESS OF PERSON WHO | | | עדד | 10 | | 00 76 | | | | | | |

COUNT

| D. | 1 1 | |
|--|-------------------------------------|--|
| Shou | | 9a. FACILITY NAME (# n |
| e | 8 | Memorial H |
| physician. burla-transit permit. Pages 1, 2, 3 should | 5 | RESIDENCE OF |
| sabe | 2 | 10a. STATE |
| ji. | 0 | MARYLAND |
| ped | ¥ | 10e. STREET AND NUME |
| n. ansit | ij | |
| Sicia fal-tr | 5 | 11. MARITAL STATUS |
| phy pur | 7 | 1 Never Married 2 |
| nding s the | 8 | Λ _ |
| or attending p | | 15. (Specify |
| al or | | Elementary/Seconda |
| ospit ched | N N | 6 |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, ID THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR | 17. FATHER'S NAME (Firs |
| GIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by te princate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at | E I | |
| should should | 0 | 19a. INFORMANT'S NAM |
| e 5 | F | KEVIN GILE |
| nay be page | | 20a. METHOD OF DISPO |
| director, or must | | 4 Donetion 5 0 |
| Pag dir | | 21. SIGHATURE OF FUN |
| funeral xamine | | × 1// |
| the oval. | | /// |
| SICIAN: The law requires that the death certificate be executed within 24 hours after or certificate has been signed by the attending physician and completely filled in by the highe State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 4, or them 23 shows any Injury, or other traumatic event, the medical e | | 23. PART I. Enter the shock, of |
| 4 ho | | IMMEDIATE CAUSE |
| nin 2 tely f matio | | disease or condition resulting in death) |
| mple crer | | |
| d co | z | |
| to the | 임 | Sequentially list con if any, leading to im |
| prior | 8 | cause. Enter UNDER |
| tifica physiene ther | Ē | CAUSE (Disease or that initiated eventa |
| h cer ndin Hyg | FR | resulting in death) i |
| deat atte ental | 岁 | |
| The state of the s | A | PART II. Other algni |
| that ned that the au | 응 | |
| quire Hea DWS | ME | |
| ICIAN: The law requires that the death certificate be enflicate has been signed by the attending physician the State Dept. of Health and Mental Hygiene prior or Nem 23 shows any Injury, or other trau | HYSICIAN: MEDICAL CERTIFICATION | DID TOBACCO |
| he la has e De m 2 | M | 25. WAS CASE REFERRE |
| Fication State | Sic | EXAMINER? |
| SICI/ certi | 소 | 27. MANNER OF DEATH |
| VG PHY ter this eath with | I D | 1 Natural 5 |
| After death s mai | ВУ | 2 Accident 3 Suicide |
| TEN TOR: after 28 19 | | 4 Homicide |
| OR ATTENDI DIRECTOR: A hours after di | <u> </u> | 29e, CERTIFIER |
| TAL O WAL D 72 ho | COMPLETED | (Check only |
| HOSPITAL FUNERAL Within 72 TANT: II | Ö | |
| THE HOTHER FOR FIRE WILL | BE C | 29b. SIGNATURE AND T |
| TH OT TH OT TH OT TH | 8 | |
| 7 | 오 | 30. NAME AND ADDRES |
| 51 | | Dr. W. Lar |

| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | IENTAL HYGI REG. | | | | |
|---|--|---|---------------------------------------|---|--------------------------------------|--|--------------------------|-----------------------|-------------------------|---------|
| 1 | 1. DECEDENT'S NAME (First, Middle, Las | 0 | | | | 2. DATE OF DEAT | н | 3. 1 | TIME OF DEAT | ГН |
| ľ | HILDA MAE | i A | GIL | ES | | January | 27, 199 | 6 9 | :56 A | M |
| ř | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Yea | 8. | | CE (Stete or Fo | oreign |
| ļ | 215-16-4446 | 1 □ M 2 🔀 F 7 | 2 YRS. | MONTHS DAYS | HOURS MIN. | JUNE 20. | | | ND | |
| ۱ | 9a. FACILITY NAME (If not institution, give | | | | R LOCATION OF DEA | 2 2 2 1 2 2 | 9c. COUNT | OF DEATH | | |
| į | Memorial Hospita | 1 & Medical C | enter | Cumber | Land | | Alleg | gany | | |
| | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | TV | 100 CITY | TOWN OR LOCAT | TION | | | 1404 | . INSIDE CITY | |
| | MARYLAND ALL | EGANY | | ROSTBUR | G | | | X | LIMITS? YES 2 - | |
| | 10e. STREET AND NUMBER | ILL STREET | | 101 | 21532 | | 10010 | N OF WHAT | COUNTRY? | |
| | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | N U.S. ARMED | | ENDENT OF HISPANI | | | | American India | en, |
| | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 TYES | | | ecify Cuban, Maxicen 2 X NO Specify: | |) | Black, Wh Specify: | ita, etc. | |
| ı | Λ | | | | | | | | WHITE | |
| Ì | 15. DECEDENT'S EI (Specify only highest gra | | 16a, DECEDENT'S L (Give kind of w | ork done during mo | ON ist of working | 16b. KIND OF | BUSINESS/INDUS | TRY | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use | | | OLTA | HOME | | | |
| 1 | 6 | | HOUSEWIE | E | 1 | OWN | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTHER'S NAM | NE (First, Middle, Me VIRGINI | | ET C | | |
| ı | JUH 19e. INFORMANT'S NAME (Type/Print) | N W. MCKENZIE | | | | | | | | |
| ı | | | | | FROSTBU | | | ode) | | |
| ı | KEVIN GILES | 1.00 | . PLACEANDDATEO | | | | LOCATION — CH | | **** | |
| | 1 Donetion 5 Other (Specify) | | netery, cremetory or off OSTBURG N | | | | | | |) |
| ł | 21. SIGNATURE OF FUNERAL SERVICE | | OSIDURG P | 22. NAME AI | ND ADDRESS OF FAC | HLITY | | , | 21701 | |
| ١ | Mil | m N | | / - | FUNERAL | | | 0 | 0 | |
| 4 | - / / larilo | 1/1/2/6 | (Were | | MAIN ST. | | | | 2 | |
| ĺ | 23. PART I. Enter the diseases, o shock, or heart failur | e. List only one cause on e | d the death. Do no each line. | ot enter the mo | de of dying, such | aa cardiac or n | eapiratory arres | it, | Approxim | |
| | IMMEDIATE CAUSE (Final | | | | | | | | Onset and | d Death |
| | disease or condition resulting in death) | • Pneumonia | | | | | | | 2 Wee | eks |
| Ì | | | A CONSEQUENCE OF |): | | | | i | untino | |
| | Sequentially list conditions, | b. Severe C.O | A CONSEQUENCE OF |); | | | | | Years | 5 |
| ı | if any, laading to immediate cause. Enter UNDERLYING | | | • | | | | ĺ | | |
| | CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF |): | | | | | | |
| Ì | resulting in death) LAST | d. | | | | | | | | |
| | PART II Other significant conditi | | | | | | | 1 | | |
| ı | PART II. Other algolficent conditi | ona contributing to deeth | out not resulting is | n the underlyin | g ceuse given in I | | S AN AUTOPSY RFORMED? | AVA | RE AUTOPSY FI | TO |
| ł | | | | | | 1 YE | S 2 1 NO | | MPLETION OF (DEATH? | CAUSE |
| | DID TODA CCO LICE COA | TRIBLITE TO CALLE | | . 5/110 5 | 7 | | | 1 [| YES 2 [] 1 | NO |
| | DID TOBACCO USE CON | TIRIBUTE TO CAUSE C | 28. PLACE OF DEAT | | _ | ₹□ | | 1 | | |
| ì | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | | | | | | |
| ı | 1 YES 2 PNO 27. MANNER OF DEATH | 1 Dinpatient 2 ER/Out 28e. DATE OF INJURY | patient 3 DOA 28b, TIME | | IURY AT | 8 Other (Specify) 28d. DESCRIBE H | | DED | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | LOO. TIME | URY WO | YES 2 NO | 200. DESCRIBE N | DW INSURT OCCU | NED | | |
| | 2 Accident Investigatio | 28s. PLACE OF INJUR | Y — At home, farm, si | | | 28f, LOCATION (St | reat and Number of | Rural Boute | Number | |
| | 4 Homicide 8 Could not i | building, etc. (Spe | icify) | , | | City or Town, S | | | | |
| | 290. CERTIFIER , TO SETTIEVING DA | VEICIAN. To the best of an in- | ulada diset | d = 0 db = 00 | | | | | | |
| | anal . | YSICIAN: To the beat of my know | | | | | | | d menner as s | stated. |
| | 29b, SIGNATURE AND TULE OF CENT | | / | | 29c. LICENSE NUM | | | | nth, Day, Year) | |
| | | 10. 41 | m mm | 1 | D25406 | THE PARTY OF THE P | | | 3(, 19 | |
| | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF D | | | | | 1 0 0 0 | | -) - | |
| | | Virginia Aven | | erland, | MD. 2150 | 12 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 3/ REGISTRAR'S SIG | | - Lanu, | 413 | J 4. | | | | |
| 1 | FED 01 144 | A Grain allevates | chardell | | | | | | | |

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

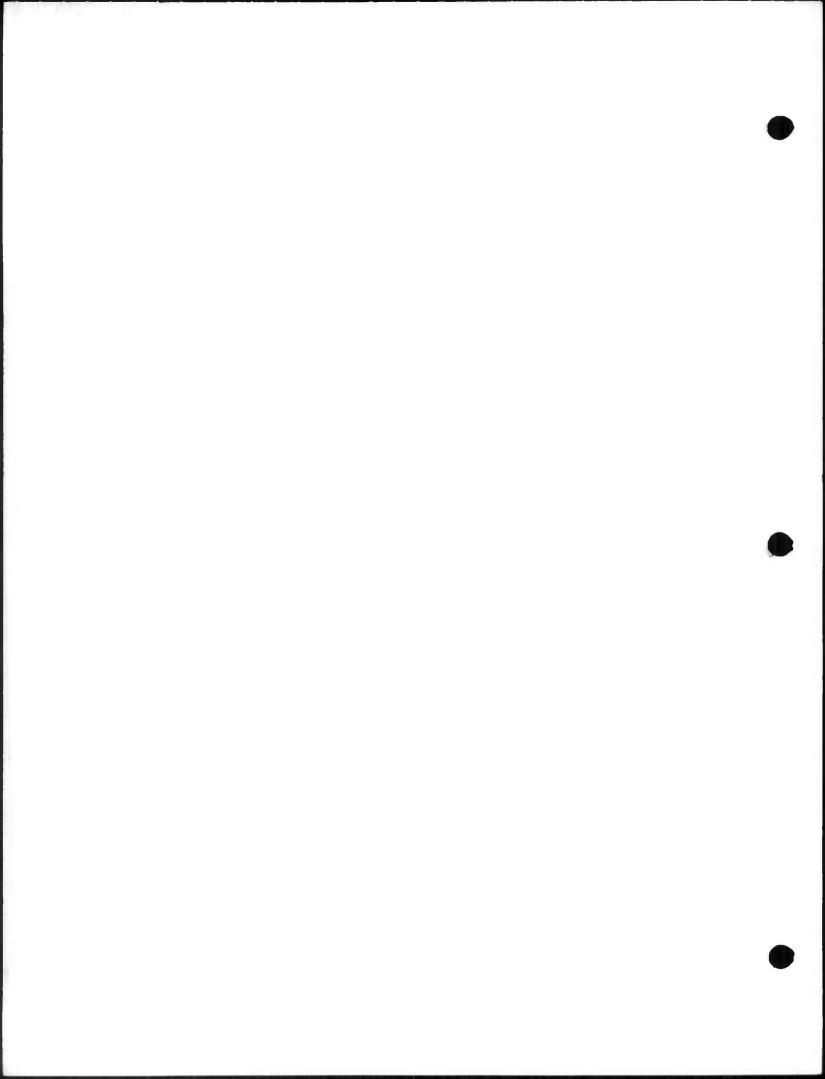
1 -

| | | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | .= | | 2. DATE OF DE | ATH DAY | | TIME OF DEATH |
|--|--------------|---|------------------------------|------------------------------------|---------------------------|-------------------|-----------------------------------|--------------------------------|--------------------------------|------------------------------|------------------|--|
| | | | | RICHARD | HARRY | GALI | ATIN | | 01 | 20 | 96 0 | 7:40+ |
| | | 4. SOCIAL SECURITY NUMB | | | AGE (In yrs. las | MOR | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BII (Month, Day. | Year) | Country) | CE (State or Foreign |
| 9 | | 201-14-7380 9a. FACILITY NAME (If not ins | | 1 XM 2 F | 71 | YRS. | | | Sept. | 29, 192 | 4 Penns | sylvania |
| . 3 should | S S | 308 Cove | | | | 96. | | ichaels | EATH | | UNTY OF DEAT | 1 |
| s 1, 2 | DIRECTOR | RESIDENCE OF DEC | EDENT 10b. COUNT | | | 1 | | | | 1.0 | | |
| 296 | I BE | 2000000 | | | | | WN OR LOCA | | | | | I. INSIDE CITY LIMITS? |
| ermit. | | Maryland 10a. STREET AND NUMBER | Talb | oot | | St. N | li chae | 1 S | | 100 0 | TIZEN OF WHAT | YES 2 NO |
| nsit p | ER/ | 308 (| Cove V | Jiew Drive | | |] " | 21663 | | | SA | COUNTRY |
| physician. burlal-transit permit. Pages 1, 2, | FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDENT E | VER IN U.S. AF | MED | 13, WAS DE | CENDENT OF HISPA | NIC ORIGIN? (Spe | cify Yee or No- | | American Indian, |
| B 8 | B | 1 Never Married 2 X 3 Widowed 4 Divor | roed | FORCES? 17 | OR DATES | | | S 2 X NO Specil | | art) | | White |
| or aftend use as | TED | (Specify only | EDENT'S EDU highest grade | CATION completed) | (G | CEDENT'S USU | done during m | ION ost of working | 16b. KIND | OF BUSINESS/IN | DUSTRY | |
| spital or ed for | COMPLET | Elementary/Secondary (0- | -12) | College (1-4 or 5+) | 1000 | 00 NOT use ret | | r Relatio | ons E | lectric | Compar | nv. |
| the hospital detached once. | O. | 17. FATHER'S NAME (First, Mid | iddle, Last) | | 1720 | ragor_ | Паро | 18. MOTHER'S NA | | | | i.y |
| d be | ш | Earnes | t R. (| Gallatin | | | | Mary | Gregg | , | | |
| 5 should | 9 | 19a. INFORMANT'S NAME (Ty | | | | | | and Number or Rural | | | | |
| page 5 | - | Eleanor A | | latin | | | | w Drive, | St. Mic | chaels, | MD. 21 | .663 |
| director, p | | 1 Donation 5 Other | n 3 🗆 Rem | ioval from State | cametary, cre | matory or other p | SPOSITION (N place) mg t or | ame of | DATE 1 | 20c. LOCATION - | | sum. Delaware |
| Page al din | | 21. SIGNATURE OF FUNERAL | | CENSEE | Capi | .01 016 | 22. NAME A | ND ADDRESS OF FA | CILITY | | | elaware |
| ter death. Pag the funeral di oval. | | Hans | ism. | E Lein | und | | | son E. Le | | | | D 2166 |
| d in by the or remove | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory street, Approximate | | | | | | | | | | |
| 7 filled in tion, or retail | | IMMEDIATE CAUSE (Fine | | | | | , | | | | | Interval Batwe Onset and De |
| | | disease or condition resulting in death) | → | MNS | mall | cell | una |) Cane | er | | | 7 Mars |
| ecuted within nd completely burial, cremat atic event, 1 | _ | | | DUE TO (OF | AS A CONSE | DUENCE OF): | | | | | | |
| 8 ° ° E | ERTIFICATION | Sequentisity list condition | | b. DUE TO (OF | AS A CONSEC | OUENCE OF): | | | | | | |
| | <u>8</u> | cause. Enter UNDERLYIN CAUSE (Disease or Injur | NG | с | | | | | | | | |
| requires that the death certificate be- een signed by the attending physician of Health and Mental Hygiene prior to shows arry Injury, or other traus | E | that initiated events resulting in death) LAST | | DUE TO (OF | AS A CONSEC | DUENCE OF): | | | | | | |
| he death certification the attending Mental Hygier | SE | | | d | | | | | | | | |
| the deal y the att nd Menta Injury, | | PART II. Other significer | | | | esulting in th | e underlyin | g ceuse given in | | MAS AN AUTOPSY PERFORMED? | | RE AUTOPSY FINDING |
| tuires that the displaying the signed by the Health and Mer DWS arry Injury | EDICAL | CATONOVY | Atten | y Disea | je | | | | 10 | . / | CON | ILABLE PRIOR TO IPLETION DF CAUSI DEATH? |
| requires seen sign of Heal | Σ | | | | | | | | _ | | 1 | YES 2 NO |
| law has be Dept. 23 s | AN | 25. WAS CASE REFERRED TO | MEDICAL | | | | | | | | | |
| SICIAN: The law requestion of the State Dept. of 1, or Item 23 sho | SICIAN: | EXAMINER? | MEDICAL | HOSPITAL: | 2/Outpetlant 2 | | HER: | LACE OF DEATH (Ch | | | | |
| SICIA certif | <u></u> | 27. MANNER OF DEATH | | 28a. DATE OF INJ | IURY | 28b. TIME OF | Nursing Hon 28c. IN. | JURY AT | 6 Other (Spec | HOW INJURY OF | CURED | |
| DING PHYS After this of death with | ВУ Р | | Pending nvestigation | (Month, Day, 1 | Year) | INJURY | M 1 🗆 | YES 2 NO | | | | |
| TOR: A after d after d 28 is | TED E | 3 Suicide 8 C | Could not be letermined | 28e. PLACE OF IN building, atc. | JURY — At ho (Specify) | ne, term, street | factory, offic | :8 | 28f. LOCATION City or Town | (Street and Number, State) | w or Rural Route | Number, |
| | F. | 29a. CERTIFIER CERTIFIER | FYING PHYSI | CIAN: To the best of my | knowledge, de | ath occurred at | the time deta | and place, and due | to the course(s) o | -dd | and a | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 P | COMPL | | | R: On the basis of exam | | | | | | | | manner as stated |
| TO THE HOSPI TO THE FUNEF DE filed within | w | 29b. SIGNATURE AND TITLE | OF CHIMIFIE | 1 | _ | | | 29c. LICENSE NUI | | 29d, DA | TE SIGNED (Mon | oth, Døy, Ybar) |
| E E S S | TO B | much | rel 7 | X29 OU | $_{\sim}$ | | | D42 | -005 | • | 01/20 | 196 |
| | ,- | 606 Dut | Chy | an S Le | of DEATH (ITER | | sto | 1 ME | | mic | havel | Lee |
| | | JAN 23 | | 32 REGISTRAR'S | | | | | | | | |
| ' | | | 1000 | The wille | AND INDIAN | all | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

, State, Zip Code) ls, MD. 21663 CATION -- City or Town, State Dover, Delaware ral Home lichaels, MD. 21663 atory screet, Approximats interval Bstween **Onset and Death** 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE WED? NO OF DEATH? 1 TES EN NO JURY OCCURED nd Number or Rural Route Number, er as stated. due to the cause(e) and manner as stated. DHMH-16 Rev 1/89



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

Certificate of Death 2. Data of Death 3. Tima of Death Month Yaar Jan. 21, 1996 Green

1. Decedant's Nama (First, Middla, Last) **Physician** MARY 3:40PM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Desth Examiner Memorial Hospital @ Easton Talbot Easton If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Days Hours Min. (Month, Day, Year) 8. Data of Birth (Month, Day, Year) MAR. 29, 1922 PENNSYLVANIA 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 1 □ M 2√2 F 73 180-16-3273 Yrs. Director Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. inaida City Limits 28a-f show the Medical Examiner must be nothing at Yas 2□ No Director NJ BERGEN ELMWOOD PARK 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 07407 USA 15 ROSEMONT AVENUE items 23a death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give X Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 6 1 ☐ Yas 2 No Specify: WHITE þ ₩idowed 4 Divorced "natural", Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) PHOTOGRAPHY EXPEDITER FOR KODAK marked other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) th and Mental I Pages 1 and 2 should be "UNKNOWN" YACYSZYN MARY ZACHARIAK 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrasa (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health ar important: If item 27 ie any injury or other treu 000.0. 231 ROOSEVELT AVE., ELMWOOD PARK, NJ 07407 THOMAS J. GREEN 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 TBurial 2 Cramation 3 Ramovai from Stata PATERSON, 1 - 25CALVARY CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on each line. 21601 Approximate Interval Between Onset and Death Physician prewnococcal Vernoma & Sepans /Medical immediata Causa (Final disaasa or condition rasuiting in daath) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated avants rasulting in death) Last Due to (or aa a consequance of): physiclan a Box 68760. **Physician/Medical** Dua to (or as a consequence of): for use as Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 ☐ Yss 2 ☐ No 3 ☐ Probably (* ☐ Unknown ģ 24b. Wara autopay findings svallabla prior to completion of cause of death? Be Completed 24a. Was an autopsy page 2 s 20108510V 1 Yas 20 No 1 Yas 2 No certificate Division of Vitai Hospital or Attending Physician: 25. Was casa rafarred to medical axaminar? 28. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 8 Other (Specify) 1 Yas 2 No Certification: To 1) ■ Inpatiant 2 □ ER/Outpatient 3 □ DOA Ar after des. 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be detarmined 3 Suicida 28a. Placa of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida within 24 hours at To the Funeral D completaly filled is Cartifying Physician: To tha best of my knowledge, daath occurred at tha tima, deta and place, end dua to tha causa(a) and menner es atated.

| Cartifying Physician: To tha best of my knowledge, daath occurred at the tima, deta snd place, and menner es atated.

| Cartifying Physician: To tha best of my knowledge, daath occurred at the tima, deta snd place, and menner es atated.

| Cartifying Physician: To tha best of my knowledge, daath occurred at the tima, deta snd place, and menner es atated. Medical (Check only one) the th 29b. Signature and title of certified 29c. Licansa number 29d. Data signed (Month, Pay, Year) 30. Nama and siddrass of person who complated causa of death (Itam 23a) (Type, Print)

606 DUTCHMAN'S LANE, EASTON, MD

21601

Registrar

MICHAEL LEES, M.D.,

JAN 22 1996

32. Ragistrar's Signatura

In d'Evileon Rardall

31. Data filed (Month, Dey, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 96

03720

| | | | | | | Cei | rtificat | e of | Death | | Re | B. No. | 0 (| 0076 | 0 |
|---|----------------|--|--|--|-------------------|-------------------------|--|---------------------|------------------------------------|---------------------------------|-------------------|-----------------|---------------------------|--------------------------------------|------------|
| Dhamba | | 1. Decedant's Neme | (First, Middle, La | st) | | | | | | | e of Deeth | Dey | Voor | 3. Time of De | eath |
| Physic /Medi | | | Isabel ! | McCarty | Gilbert | | | | | | nuary | | 996 | 9:45 | PM. |
| Exami | | 4e. Fecility Neme (# | not institution, giv | e street and numbe | or) | | | | 4b. City, Town | | | 4c. County | of Deeth | | |
| | | MONTGO | MERY GEN | ERAL HOSP | TAL | | | | OLNE | EY | | MO | NTGOM | ERY | |
| Funerai | | 5. Sociel Security Nu | | | Age (In yrs. lest | | If Under Months | 1 Yeer Deys | | Min. 8. Det | e of Birth | Year) | 9. Birthp | olece (State or F | oreign |
| Director | | 189-36-10 | 379 | □M 217 F | 91 | Yrs. | - INIONALIO | Doyo | 110010 | FE | B. 2 | 1,1904 | F | A. | |
| p . | | Usuel Residence of 10a. Stete | | | 40° Oib. T | | | | | | | | | | |
| anyla | 2 | | 10b. County | | 10c. City, To | JWII OF LO | | | | | | | 1 | 10d. Inside City I | |
| Ne M | oto | MD. | MONTGO | MERY | | | | KVI | LLE | | | | | 1- Yes 2 | LINO |
| is 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. Ifem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at | Director | 10e. Street end Num | ber | | | | 10f. Zip | Code | | | 10 | g. Citizen of \ | What Cour | ntry? | |
| ath v | Funeral | 5901 1 | MONTROSE | RD. #N90 | | - | | _ | 0852 | | | | .S.A. | | |
| er de | nue. | 11. Meritel Stetus | | 12. Was Deceder Armed Forces | s? | 13. \ | Nes Deced f Yes, spec | dent of cify Cut | Hispenic Orlgin sen, Mexican, F | n? (Specify Ye Puerto Rican, | s or No- etc.) | | ce - Americ ck, White, | | |
| S aft | by F | 1 Never Marrie | | 1 ☐ Yes 2 ☐ | | | 1 □ Yes | 2 🔯 No | Specify: | | | Specifi | y: | | |
| 2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or items: reumatic event, the Medical Examiner ma | | 3 ₩ Widowed 4 | | Year or Detes | | | | | 5.00 | | | | | HITE | |
| d within 72 hours at giene. or than "natural", or | Completed | (Specif | Decedent's Ed y only highest gra | ducation ide com <i>pleted)</i> | 16 | (Give | tent's Usua kind of wo DO NOT us | rk done | during most of | f working | 1 | 6b. Kind of B | usiness/in | dustry | |
| with! | E | Elementary/Secon | dery (0-12) | Coilege (1-4o | r 5+) | me. t | HOUS | | • | | | 0.0 | D 17.0 | NA (TIT) | |
| should be filed with nd Mental Hygiene. marked other than umatic event, the | | 17. Father's Neme (F | First Middle Last | 2 | | | 11005 | TWEE | | Neme (First, | Middle M | A. | | MATER | |
| d 2 should be filk th and Mental Hy 7 Is marked oth traumatic event | Be | ROBEI | _ | | A TOUTS | | | | TO. WIGHT S | | | | | | |
| d Me | 2 | | | | ARTY | 66 E4-20- | | (0) | | | MAE | | BROOK | | |
| d2 s h an 7 ls r | | 19a. Informent's Ner | | | ' | _ | | | t end Number o | 11 | Number, | City or Town, | Stere, Zip | Code) | |
| pemit. Peges 1 and 2 Department of Health a Important: If frem 27 h any injury or other tra once. | | 20e. Method of Dispo | M E. GIL | REKT. | 20b. Plece | | AME sition (Ner | AS ne of | ITEM | #10 | | Do Loonting | ChuorTe | num Ctata | |
| vermit. Peges 1 ar Department of Hea mportant: If them iny Injury or other MCs. | | , | | Removel from Stet | 00000 | itery, cren | netory or o | ther ple | ece) | 1500 | | Oc. Location - | City of 10 | JWII, Stele | |
| tmer tant: | | | 5 Other (Specif | | CHAM | BERS | CREM | IATO | RY | 1/29 | /96 | RIVE | RDALE | , MD. | |
| Depar Impor any in | | 21. Signeture of Fun | erei Service Elcar | 1500 | 2 | 22 | . Neme en | nd Addr | ess of Fecility | | | | | | |
| 907 9 0 | | W.M | Chan | neene | M0009 | 1 1 | W.W. | CH | AMBERS | CO. IN | CS1 | LVER S | SPRIN | G, MD.2 | 009 |
| 71 | | 23a. Pert1. Enter the | e diseese, or com | plications that cause one cause on each | ed the deeth. D | o not ent | er the mod | le of dy | ing, such es ca | rdiac or raspin | atory erras | st, | | Approximata Interval Between | |
| Physician | | | Tonor Editorny | 0.10 0.2000 0.11 0.001 | | | | | | | | | | Onset and Dec | əth |
| /Medical | | Immediate Cause (F | | · Prey r | 2mis | | | | | | | | 1 | 17 das | 41 |
| Examiner | | resulting in deeth) | | | D | a consec | uance of): | | | | | | | | (- |
| D 2 | ner | | | Chron | | | | | y Desci | inc. | | | 1 | 17 day | (1) |
| oute | Examiner | Sequentielly list con- | ditions. | b. ———— | Due to (or es | | | |) | | | | | | |
| an a | | Sequentielly list con- if any, leeding to immoduse. Enter Underl Ceuse (Disease or in thet initiated events | nediate lying | | | | | | | | | | i | | |
| ificete be exe g physician e as the burial- | edical | thet initiated events resulting in death) La | njury | C | Due to (or es | e conseq | uenca of): | | _ | | | | - | | |
| death certificate be executed e attending physician and of for use as the burial-transit | Med | resulting in death) La | 150 | | | | | | | | | | | | |
| h ce endir | | | | d | | | | | | | | | | | |
| 9 0 0 | Physician/ | Part II. Other signiffo | ant conditions o | ontributing to death | but not resulting | In the ut | nderlying c | ause oi | ven in Pert I. | 23 | b. Did tob | acco use co | ntribute to | the cause of d | death? |
| requires that the seen signed by the | hy | | | | | - | | | | | 1 🗆 Yes | 2 No | 3 Pro | bably 4 Don | know |
| signed de det | by F | | | | | | | _ | | | | | | | |
| v require been sig | | | | | | | | | | 24 | a. Was en | | 24b. W | are eutopsy find eilabla prior to | lings |
| | et | | | | | | | | | _ | perform | ear | co | mpletion of caus | 80 |
| B | Completed | | | | | | | | | | 1 ☐ Yes | 2 0 No | | ☐Yes 2☐ No | |
| icedificate | | 25. Was case rafarra | d to medical | - | | | . <u>-</u> | | DC Diago of | Death (Char | | | | J 165 Z L 140 | |
| | o Be | exeminer? | | Hospital: | ** 0 D E D # | 0.44: | | . Ot | hor | Death (Chec | | | (0 | | |
| Phys ral d | 5 | 27. Manner of Deeth | 10 | 1 Mainpai | | Outpatien o. Time of | | /A | 4 LI NUISI | ng Homa 5 | | v Injury occur | | γ) | |
| or Attending Phatter death. Nector: After this in by the funeral | tior | 1 SNeturel | 5 Pending investigetion | 28e. Date of In (Month, D | ley Year) | Injury | М | Bc. fnju Wo | rk?]Yes 2∐ No | | | ,,,,, | | | |
| death. ctor: A y the fu | lica | 2 Accident 3 Sulcide | 6 Could not be | | njury - At home, | farm str | | | | | eation (Stre | et and Numb | her or Run | al Route Number | r |
| l or Attending lafter death. Director: After | Certification: | 4 Homicide | determined | building, | etc. (Specify) | TELLITI, OLL | 551, 160101) | , omos | | Cit | y or Town, | Stete) | | | , |
| phras and a second | | 29e. Certifier | To de de on | unfalon. To the hear | A ad lanedd | an death | | | | dan land dis | A market and a | (-) 4 | | | |
| To the Hospital within 24 hours a To the Funeral Completely filled | edical | (Check only 2 | Medical Exam | ysician: To the bes niner: On the basis | of exemination | ge, deeth end/or inv | estigetion, | in my | me, date end p opinion, daath | occurred at th | e time, dat | a and plece, | and due to | tated. the cause(s) | |
| within 2 To the | Mec | 29b. Signeture end ti | tle of certifier | end menner s | statao. | | 290 | Lican | se number | | 29 | d. Date signe | d (Month | Dev Year) | - |
| F ≥ F 8 | | 1.5 | 1 | | | | | | | | 23 | | | 1 | 22 |
| | | you | Yolla | A-P | | | 1 | ٥١٥ | 1 -6 | | | 124/4 | 76 | Arrary 2 | 5/ |
| | | 30. Neme end eddres | . () | completed dausa of | death (Item 236 | (Type, | Print) | MI | 726 |) | | | | 111 | 6 |
| | | 10101 | PAINC | " | or, | ULNO | -41 | - / 2 | 0008 | | | | | | |
| Sta | | 31. Dete filed (Month | C | | trar's Signeture | | * | | | | | | | | |
| Registr | ar | JA | N 3 0 199 | 16 Julia | Muchant | anda H | | | | | | | | | |
| HMH 16 Rev 6/9 | 5 | | | | | | | | | | | | | | |

all Design and Topic V 60 25 THE TAX a topic topi graphical classiff for even 8 Brought of the stage of the sta

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State of Maryland / Department of Health and Mental Hygiene

| _ | | | | | | | Ce | rtificate of | | | Reg | | טכ | 03121 | |
|---|---|------------------|--|--------------------------|-------------------------------------|--|--|---|---------------------------------------|--------------------------------------|---------------------|------------------------|-------------------------------|---|--|
| | Physic | ian | 1. Decedent's Name (First, A | fiddla, Lasi | | | | | | 2. Dete of Month | | Day | Yeer | 3. Time of Deeth | |
| | /Medi | | Morris | | | | non | | | Frua | | 26 | 96 | 10:35 Pm | |
|) | Exami | ner | 4a. Facility Neme (If not instit | | | nber) | | | 4b. City, Town, | | eath | 4c. County | of Death | | |
| | | | Suburban Ho | _ | | | |) If Under 1 Year | Betheso | | D. I | | tgomer | | |
| | Funeral Director | | 5. Social Security Number 578–42–6851 Usual Residence of Decedan | | X M 2□ F | 7. Age (In | yrs. last birthday 4 Yrs. | Months Days | | lin. 8. Date of (Month) | Day, Yo | 1902 | 9. Birthpia Counti Gern | aca (Stata or Foraign ny) nany | |
| pue | 1 | | 10a. Stete 10b. Co | | | 100 | c. City, Town or L | ty, Town or Location | | | | | 10 | d. Inside City Limits | |
| Man | a-f ahow | tor | MD Mor | tgome | ery | | Rockvi | | | | | | | OXONYes 2 □ No | |
| and 21215-0020 be filed within 72 hours after death with the Maryland | af, or items 23s or 28s-f show | Funeral Director | 10e. Street end Number 6121 Montros | se Roa | ad | | | 10f. Zip Code 20852 | | | | . Citizen of V | What Countr | ry? | |
| 90 | E B | ner | 11. Marital Status | | 12. Was Dece | dent Ever | in U,S. 13. | Wes Decedent of If Yes, specify Cul | Hispanic Orlgin? | (Specify Yes or | No- | | e - America | | |
| 020 ours after | "natural", or its | by | 1 Never Merried 2 ☐ 3 🖾 Widowed 4 ☐ Divo | | 1 Yes If Yes, Give Year or De | 2 X No | | 1 ☐ Yes 2 █€No | | ierto riloan, etc. | | | ck, White, e | | |
| 15-0 72 h | ital Hygiene. d other than "natur event, the Medical | Completed | 15. Dece (Specify only hi | dent's Edu ghast grad | ication le complated) | | 16a. Dece (Givi | edent's Usual Occu a kind of work done DO NOT use ratin | pation during most of | working | 16 | b. Kind of Bu | usinass/Indu | ustry | |
| 12 12 | then the M | dmo | Elamentary/Secondary (0- | 12) | College (1- | -4or 5+) | Tim | | 90) | | | Deize | .+. | | |
| D | other vent, ti | | 17. Fether's Neme (First, Mid | die. Last) | | | 1 111 | DEL | 18. Mother's I | Name (First, Mic | Idle. Mai | Priva dan Sumam | | | |
| Maryland 21215-0020 | and Mental Hygiene. is marked other than sumatic event, the M | To Be | Abraham Eli | | rossman | | | | | (unknow | | | | | |
| Aar 2 sho | th and Mer 7 is marks traumatic | | 19a. Informant's Name/Relet | ionship (T) | ype, Print) | | 19b. Mail | ing Address (Stree | t and Number or | Rural Routa Nu | mber, C | ity or Town, | State, Zip (| Code) | |
| | # 61 F | | Charles Freu | ınd/Gı | candson | | PO B | ox 11221 | Washing | | | | | | |
| Baltimore, | nent of Hear rut: If Item rry or othe | | 20a. Method of Disposition 1 □ □ Cremet 4 □ Donetion 5 □ Other | ion 3 □F | Removal from S | State 2 | | osition (Nama of matory or other pla Mem. Gard | _ | 1/28 | | c. Location - lney, | | m, State | |
| an ti | Baltimor permit. Pages: Department of Important: If he any Injury or of once. | | 21. Signature of Funeral San | nce Moens | 88 | | 2 | 2. Name end Addr | ess of Facility | | - | | | | |
| o seesa | | | 19/A | | | | | 22. Name end Address of Facility Edward Sagel Funeral 1 | | | | | Direction ckville MD 20852 | | |
| | | | 23a. Part1. Enter the shock, or heart failure. | of compl | lications that ca | aused the | deeth. Do not en | iter the mode of dy | ing, such as card | fiac or respirato | y arrast | LIE ML | | Approximata Interval Between | |
| 68760, tificate be executed U | g physician and se the burial-transit | edical Examiner | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | { | | Due - U.M. Dua | ATOR) to (or as a conse O / / A to (or as a conse to (or es e conse | quenca of): | VILUR | | | | | | |
| | | Physician/Me | | | d | | | | | | | | 1 | | |
| - i | the a | ysic | Part II. Other significant con | ditions cor | ntributing to dea | death but not resulting in the underlying cause given in Part I. | | | 23b. I | Old toba | cco usa col | ntributa to | the cause of death? | | |
| P.O. | ed by detac | | DEHYORA | 7101 | 2 | | | | | _ | ☐ Yes | 2 No | 3 Probe | ably 4 Unknow | |
| Records, P.O. Box | been sign should be | Completed by | | | | | | | | | vas en a | | avai | re eutopsy findings liable prior to apletion of cause | |
| Rec e law | has l | mpl | | | | | | | | | | _ | of de | eath? | |
| = F | | | or W | | | | | | | | ☐ Yes | 2.2 No | 10 | Yas 2□ No | |
| Sea V | s certific director, | Be | 25. Was case rafarred to med examinar? | | lospital: 🙏 | | | 0 | har | Death (Check or | | | | | |
| Phys Of | | - T | 1 ☐ Yes 2 No 27. Manner of Death | | 142 In | | 2 ER/Outpatle | nt 3LI DOA | 4 LI Nursin | g Home 5 F | | a 8 □Oth | | 1 | |
| O Bug | After funer | tlon | 1 Natural 5 □ Pe | nding estigetion | 28a. Date of | Day Yes | ar) Injury | Wo | ork?]Yes 2 □ No | 200. DESC | De HOW | injury occur | 160 | | |
| Division of Vita | after death. Director: Al in by the fu | Certification: | 3 Sulcide 6 □ Co | uld not be lermined | 28e. Place of building | of Injury - g, etc. (S _i | At home, farm, st pacify) | reet, factory, office | | | n (Stree Town, S | | er or Rural | Route Number, | |
| Hospita | Funeral Funeral tely filled | edical Co | 29a, Certifiar 19 Certification (Check only one) | fying Phys | nar: On the bas | sis of exam | knowledge, deat | h occurred at the to evastigation, in my | ime, date and ple opinion, death o | ace, and due to courred at the th | the caus | e(s) and ma | anner as sta and due to t | ited. the cause(s) | |
| To the | within 2 To the comple | Me | 29b. Signature end title of cer | tifier | end menne | ei siaied. | | 29c. Licen | se number | _ | 29d | Date signer | d (Month. D | lay, Year) | |
| ř | ≯ | | mu | on | un | nu | 1 | D39 | 5791 | | / | /27 | 196 | | |
| | | | 30. Name and address of per | | omplated cause | of death EOE | (Îtem 23a) (Type, 261A A | VE, SI | LVER | SPRI | NB | , MC |) Ze | 1902 | |
| | Sta Registr | 90460 | 31. Date filed (Month, Day, Y. | 3 0 1 | | gistrar's S | | | | - | | | | | |
| DHMH | 16 Rev 6/9 | 000 | JAN | บปไ | 220 % | wa w | -wager Wild | WIN. | | | | | | | |

Registrar DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 96

| | | | | | | Ce | rtificate | of | Death | | | Reg. No. | | |
|------------|--|--------------------|--|--|--|---|---|------------------------|-----------------------------|------------------------|---|----------------------------------|----------------------------|--|
| | Physic /Medi | | Decedent's Nama (First, Midi ALEXANDER | dia, Last) | | GARBE | ER | | | | 2. Data of De Month JANUARY | ath | 99 ^{Year} | 3. Time of Death 7:00 PM |
| 7 | Exami | | 4a. Facility Nama (If not instituti 8100 CONNECTI | | , | | | | CHEV | Y CH | ocation of Death | | ty of Death | |
| | Funeral Director | | 5. Social Security Number 173-24-9053 Usual Rasidence of Decedant | 6. Sax 1 X M 2 □ F | 7. Aga (In yr | s. last birthday) Yrs. | If Undar 1 Months I | Yaar Days | | 24 Hrs. Min. | 8. Data of Bir (Month, Da JULY 19 | th, Year) 9, 1912 | 9. Birth Cou NE | placa (Stata or Foreign intry) W YORK |
| | he Maryland 18a-f ahow our ed at | ector | 10a. Stata 10b. Count FLORIDA BRO | y WARD | | City, Town or Lo | D | | | | | | | 10d. Insida City Limits 1 ☐ Yas 2 ☐ No |
| | 23a or 2 | Funeral Director | 10a. Street and Number 2751 S. OCEAN | DRIVE, #30 | O8N | | 10f. Zip C | oda 01 | 9 | | | 10g. Citizan of UNITEI | | |
| 0000 | 72 hours after death with the Maryland "naturel", or Neme 23a or 28a-f show solded Examiner must be notified at | by | 11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒ Divorce | rried 1 [2 Yas | 2 □ No | | Was Deceder If Yas, specify 1 ☐ Yas 2 ☐ | | | lgin? (Sp n, Puarto | pecify Yas or No Rican, atc.) | 14. Ra Bli Speci | ack, Whita, | can Indian, , atc. HITE |
| 21215-0020 | C . 0 | Completed | 15. Deceds (Specify only high Elamantary/Secondary (0-12) | nt's Education ast grade completed Collaga |) (1-4or 5+) | (Giva | dant's Usual (kind of work DO NOT usa | Occu dona retire | petlon during mos d) | t of work | king | 16b. Kind of I | Businass/ir | |
| Maryland | ges 1 and 2 should be filed within to Health and Mental Hygiene. If frem 27 is marked other than or other traumatic event, the Mental Hygiene. | To Be C | 17. Fathar's Nama (First, Middle DAVID GAR | | | , | | | 18. Moths | | na (First, Middla, KOR | , Maiden Sume NBLOOM | ma) | |
| | 1 and 2 sho Health and In 27 is m | | 19a. Informant's Name/Ralation | ship (Type, Print) DAUGHTER | | | | | | | ral Routa Numbe | | | p Code) |
| Baltimore, | Partition of the Partit | | 20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Othar (| | DIAIR | Placa of Dispo cam <i>atary</i> , cred ENORAH | GARDEN | S | | | Data 2/1/96 | | LLE, | MARYLAND |
| Ball | permit. Pag Department Important: h any Injury o | | 21. Signatura di Funaral Sarvic | a Licansaa | 1 | | | | | | MEMORI E - ROC | | | |
| | Physician /Medical Examiner | ner | 23a. Part1. Enter the disaase, of shook, or haart failura. Lie immediate Cause (Final disaasa or condition rasulting in daath) | or complications that at only one cause on a. | caused the da | | | | | | | | | Approximate Interval Potential Onset and Depart |
| ox 68760, | death certificate be executed e attending physician and of for use as the burial-trensit | n/Medical Examiner | Saquantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. d | Dua to | (or as a consec | quance of): | | \ | | | | | (-5 |
| P.O. B | that the ed by the | by Physician | Part II. Other significant condit | ions contributing to o | death bet-ear re | esuting (Fi) u | (0) | 2 | ven in Part I | | | tobacco uae c Yes 2□ No | | to the cause of death? |
| Records, | | Completed b | | (|) | | | | | | | an autopsy ormed? | a | Vara autopsy findings vallabla prior to omplation of causa death? |
| Vital Re | ician: The law certificate has b rector, page 2 s | | 25. Was casa refarred to medic | al T | | | | | 20 Diggs | of Dool | 1 ☐ ¹ | 0 | 1 | □Yes 2□No |
| > | Physician: this certific | o Be | axaminar? 1 ☐ Yas No | Hospital: | Inpatiant 2 | ☐ ER/Outpatler | nt 3□ DOA | Ot | har: | irsing Ho | 1- | danca 6 □O | har (Snaci | (f ₁) |
| ion of | Attending Phy or death. ector: After thii by the Iuneral o | ation: T | 27. Mannar of Death Natural 5 Pend 2 Accidant Invas | 28a. Data | of Injury oth, Day Yaar) | 28b. Tima o Injury | | . Inju Wo | | | 28d. Dascribe I | | | 97 |
| Division | al or Attending Is after death. I Director: After in by the Iune | Certification: | 3 ☐ Suicida 6 ☐ Could | mined Zoa. Plac | a of Injury - At ling, atc. (Spec | homa, farm, str cify) | raat, factory, c | ffica | | | 28f. Location (: City or Tox | Streat and Num wn, State) | ber or Rui | ral Routa Number, |
| | To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the | edical (| 29a. Certiflar (Check unit) of e) Certifly 2 Medica | ng Physician: To the Examiner: On that and man | e best of my kr pasis of axamir nnar stated. | nowledge, death nation and/or In | n occurred at vastigation, in | the ti | me, date an opinion, daa | d place, th occur | and due to the red at tha tima, | cause(s) and n data and place | nanner as : , and dua ! | stated. to the causa(s) |
| | To the To the Complex | M | 29b. Spaatura and itla of caltif | War to | 1 10 | (L. W. | 29c. L | ican | sa number | 4 | 2 | 29d. Dale sign | ed (Month, | Day, Year) |
| 5 | | | | | D - 15 | 235 SHA | DY GRO | VE | ROAD | - R | OCKVILL | E, MARY | LAND | 20850 |
| | Sta Registr | | 31. Data filed (Month, Day, Year JAN 3. | 1996 32. | egistrar's Sig | Leon Rando | Ц | | | | | | | |

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State of Maryland / Department of Health and Mental Hygien

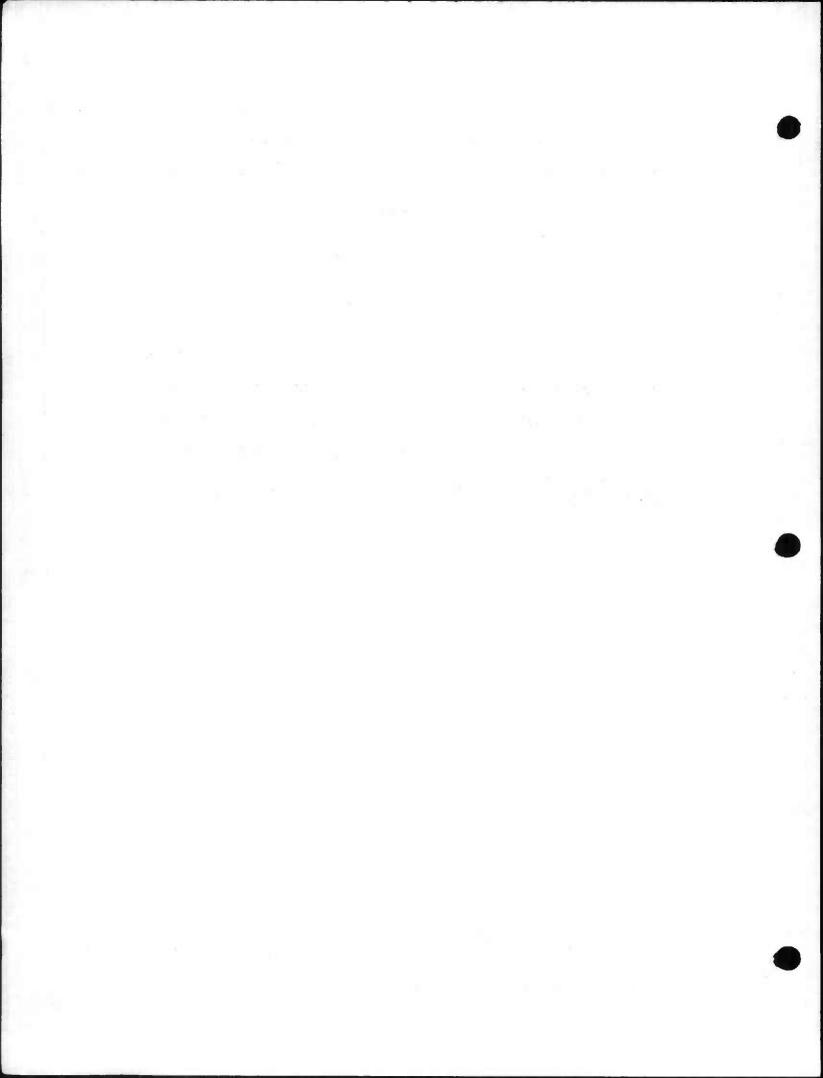
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** January 24, 1996 Conley William Hall 5:25 am /Medical 4b. City, Town, or Location of Death 4e. Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert 7. Age (In yrs. lest birthdey)

82 Yrs. Hours Deys Hours Min. Jan. 1944

18 Date of Birth (Month, Day, Year) 914 5. Social Security Number Birthplace (State or Foreign Country)
VA **Funeral** 1₽M 2□F 235 14 4892 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Chesapeake Beach Calvert MD Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Herns 23a 8402 E street USA 20732 Pages 1 and 2 should be filed within 72 hours after death tent of Health and Mental Hygiena.
nt: If Item 27 is marked other than "natural", or Items 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Welder US Gov't. 3 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Hall Sturdivant Elbert Monroe Caroline 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 133 Garner Ave., Waldorf, MD 20602 Department of Health a Important: If Item 27 is any injury or other tra Willard Hall (son) 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, Stete Southern Mem. Gardens 1-26-96 Dunkirk, MD 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, Owings, MD deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, Party Enter the disaffate, or complications that caused the shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Deli The law requires that the death certificate be executed attending physician and for use as the bunal-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of): signed by the aid 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. erebro vascula accident. Ry 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by Cashructice Palmay Disen 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Wes an autopsy performed? Prim. Enduly 1 □ Yes 2 □ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stell filled in by the funeral director; p 25. Wes case referred to medical axeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2016 1 Yes 28c. Injury et Work? Certification: 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as stated. within 24 hou To the Funer completely fil Medical 29e. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) m. D 26 Physic Allend 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 110 HOUP RD A.T. MUNSHI, M.D Surt 303 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Davidson Randall JAN 3 0 1996

DHMH 16 Rev 6/95

Registrar



| | DAKE IMONE, MANI LAND 21213-0020 |
|---|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | rs after death, Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | n by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 show |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | edical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | TMENT OF I | | MENTAL | HYGIEN REG. NO. | | | |
|---|--|---|--|---|---|----------------------|-----------------------|-------------------------|-----------------------|--|
| 8 | t. DECEDENT'S NAME (First, Middle, Lost) Edward Georg | | | kins | | Jan | . 2 | 7 19 | EAR | 1:05 P: |
| 78 | 4. SOCIAL SECURITY NUMBER 212-14-5107 | | n yrs. lest birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE ((Month) | 22/19 | tober *. | BIRTHPLAC Country) | PA |
| TOR | Physicians Memorial Hospital Physicians Memorial Hospital Residence of Decement Physicians Memorial Hospital Physicians Me | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | rles | 10c. CIT | y, town or Loca aPlata | TION | | | | | LINSIDE CITY LIMITS? XYES 2 NO |
| FUNERAL | 214 Oak Ave. | | | 10 | 20646 | | | U.S | OF WHAT | COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | II yes, sp | CENDENT OF HISPAN secify Cuban, Mexica 3 2 NO Specify | in, Puerto R | | or No.— 14. | Bleck, Wh | Amarican indian, alte, etc. Black |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementery/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16e. DECEDENT'S (Give kind of the Do NOT u | USUAL OCCUPATI work done during me se retired.) | ON ost of working | 16b. | | truct | | |
| ш | 17. FATHER'S NAME (First, Middle, Last) Edward D. Hawki | ns | | | 18. MOTHER'S NA | | | | ins | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Eleanor T. Hawk | kins | | | end Number or Rural I | | | | de) | |
| | | | | | | | or Town, | sum. ta,MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0945 MO0945 AREHART-ECHOLS F P.O. Box 567 LaP | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ceuse on e | ech line. | | | h aa card | lac or reapi | ratory arrest | | Approximate Interval Between Onset and Death |
| Z | | DUE TO (OR AS A | CONSEQUENCE O | 1 | _ | | | | | 6 day. |
| CATIO | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | c. Mutus | he p | K: Wasterto | Concer | in. | lem | ٦٠ | | 30 day |
| CERTIFICATION | that initiated events resulting in death) LAST | d. Prote | LI (CE | F): | | | | | | 54eur |
| MEDICAL (| PART II. Other significant condition | e contributing to deeth b | ut npt recuiting | In the underlyin | g cause given in | Part I. | 24a. WAS AN PERFOR | RMED? | COA OF | RE AUTOPSY FINDINGS REABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 PRO |
| | DID TOBACCO USE CONT | | F DEATH Y | | | N 🗆 | | | | j tes z je no |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | OTHER: | ne 5 🗆 Residence | 8 Other | (Specify) | | | |
| ву РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIN | JURY W | JURY AT ORK? YES 2 NO | 28d, DE\$ | CRIBE HOW I | NJURY OCCUP | RED | |
| 266. PLACE DE INJURY — Al home form office 1984 I OCATION (Small and Mumber or Dural Double Mumbe | | | | | | | | Number, | | |
| COMPLETED | one) | ICIAN: To the best of my know | | | | | | | | 1 manner es stated. |
| 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | nth, Day, Year) 8-96 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Typ | o, Print) | | | | | | |

Arthur Wooddy MD 100 Washington Ave. P.O. Box 430 IaPlata, Maryland 20646

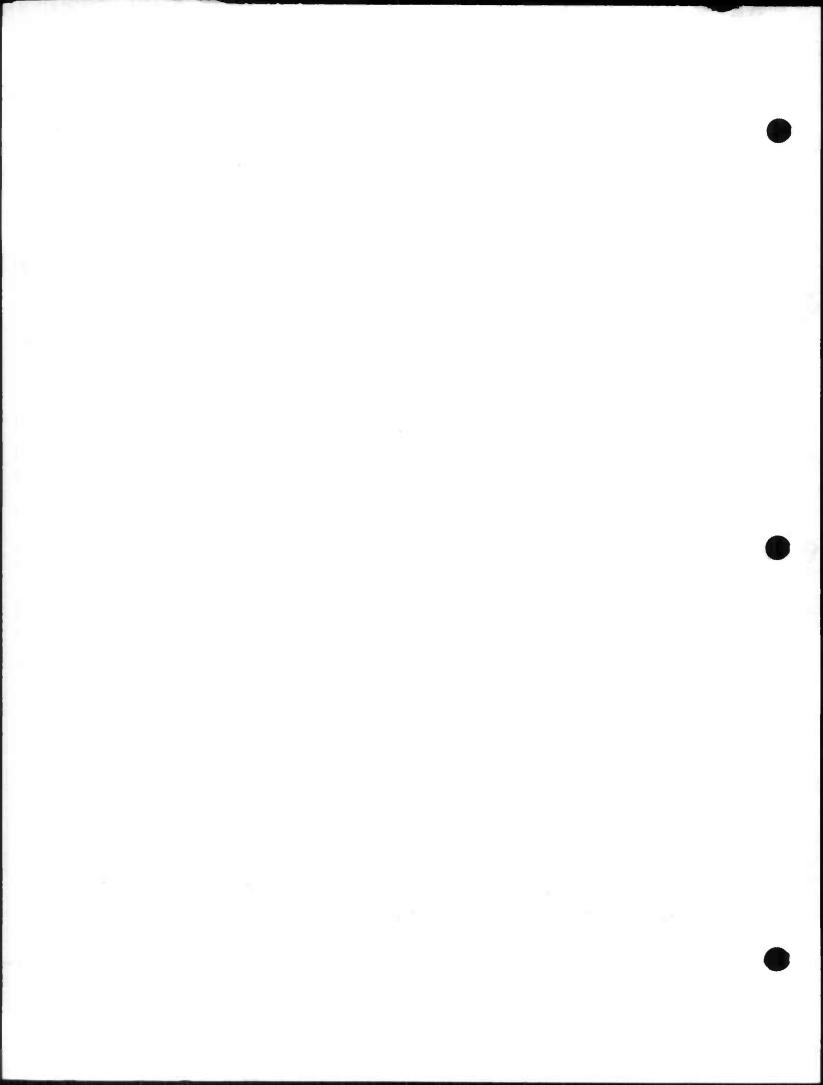
31. DATE FILED (Morith, Day, 1987)

JAN 3 1 1996

32. REMISTRAR'S SIGNATURE

JULY D'ANGLEH

JAN 3 1 1996



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

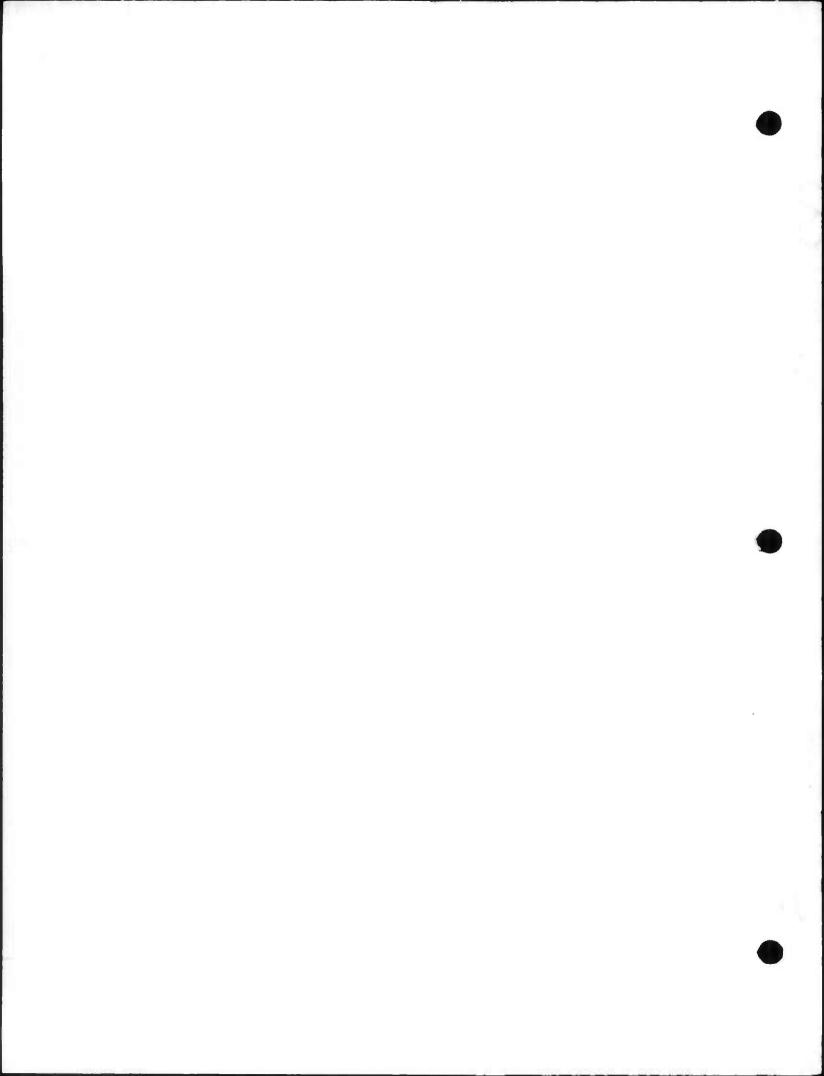
| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF HEALTH AND CATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | | |
|--|--|--|--|---|--|---------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Ambrose | J. | Ho | artman | 2. DATE OF DEATH MONTH DAY | YEAR OL | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 213-05-9227 98. FACILITY NAME (If not institution, give st | 5. SEX 6. AGE | 91 YRS. | F UNDER 1 YEAR | 7. DATE OF BIRTH (Month, Day, Year) 11/8/04 | Md Md | HPLACE (State or Foreign rry) | | | |
| TOR | Snow Hill Nusing | | 9 | Snow Hill | EATH | er er | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | ester | | TOWN OR LOCATION OMOKE | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| FUNERAL | 100. STREET AND NUMBER 10400 Market St., | Newtowne And | te R_2 | 101. ZIP CODE 21851 | | 10g. CITIZEN OF | WHAT COUNTRY? | | | |
| BY FUNE | 11. MARITAL STATUS 1 Never Married 2 Married SC Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES | N U.S. ARMED 2 XNO | 13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 XNO Specify | nn, Puerto Rican, etc.) | or No — 14. RAC Blac Spec | E American Indian, k, White, etc. White | | | |
| COMPLETED | 15. OECEDENT'S EQUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | | k done during most of working retired.) | 16b. KIND OF BUSI | | | | | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | | Bus Driv | | Baltimore AME (First, Middle, Melden S | | t Co. | | | |
| BE | Michael Itmatrius 198. INFORMANT'S NAME (Type/Print) | Hartman | 19h MAILING A | Elizabe | th Carsons | State 7in Cadal | | | | |
| 5 | Annette Staubs | | | wlend Rd., Poc | | | | | | |
| | 20s. METHOD OF DISPOSITION TY Burisl 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | October 1 Con State | b. PLACEAND DATE OF metery, crematory or other cak Lawn Ce | metery | 1/23 Balt | cation - city or to | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Melson Funeral Home PO Box 64, Pocomoke, Md. 21851 | | | | | | | | | | |
| | 23. PART I. Enter the diseasea, or c shock, Dr heert feilure. I IMMEDIATE CAUSE (Final disease Dr condition resulting in death) | s. Rec | each line. | Carcir | th as cardiec or respire | atory arrest, | Approximata Interval Between Onset and Death | | | |
| CERTIFICATION | Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in desth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificant condition. | a contributing to death a | out not resulting in | the underlying cause given in | Part i. 24a. WAS AN A PERFORM | MED? | D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 6 | 26. PLACE OF DEATH (CA | neck only one) | | | | | |
| HYS | 1 🗌 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Out 28s. DATE OF INJURY (Month, Day, Year) | patient 3 DOA 4 | Nursing Home 5 Residence DF 28c. INJURY AT | 6 Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCURED | | | | |
| ED BY | 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be | | Y — At home, farm, atre | M 1 YES 2 NO | 281. LOCATION (Street an City or Town, State) | nd Number of Rural | Route Number, | | | |
| 4 Homicide detarmined detarmine | | | | | | | | | | |
| TO BE C | 295 SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WHO | taus | A | a series | MBER 29// | 29d. DATE SIGNED | 9/96 | | | |
| 4 | 31. DATE FILED (Month, Day, Year) JAN 24 1996 | 32. REGISTRAN'S SIGN | | noke Ci | ty, N | 10 2 | 1851 | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within wours after death. Page 6 may be retained by the hospital of | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M | MENTAL HYGIENE |
|--|----------------|
| CERTIFICATE OF DEATH | BEG NO |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF HEALTH / | | TAL HYGIENI REG. NO. | | | |
|------------------|--|--|---------------------------------|--------------------------------|----------------|---------------------------------|----------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. D/ | ATE OF DEATH | | 3. TIME OF DEATH | |
| 10 | Thomas Edward Ha | amilton | | | | nuary 19 | | 12:40 a M | |
| 1 | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLI MONTHE DAYS MALER AND (Month, Day, Year) Country) | | | | | | | | |
| 1 8 | 212 - 94 - 0094 | 1 M 2 - F | 29 YRS. | ONTRS DATS HOURS | | ber 2, 1 | | aryland | |
| _ | 9a. FACILITY NAME (If not institution, give s | | | Bb. CITY, TOWN OR LOCATION | OF DEATH | | 9c. COUNTY OF | DEATH | |
| DIRECTOR | 102 Wallace Avenue North East Cecil | | | | | | | | |
| E C | 10a. STATE 10b. COUNT | Y | 10c. CITY, | TOWN OR LOCATION | | | | 10d. INSIDE CITY | |
| HG | Maryland | Cecil | | North Eas | st | LIMITS? | | | |
| AL | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | | 10g. CITIZEN O | F WHAT COUNTRY? | |
| FUNERAL | 102 Wallace Aven | iue | | 21 | 901 | | Unite | d States | |
| 2 | 11. MARITAL STATUS | 12. WAS DECEOENT EVER IN FORCES? 1 X YES | | 13. WAS DECENDENT OF | | | or No- 14. R/ | ACE — American Indian, ack, White, atc. | |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 ☐ YES 2 🔀 NO | | no mean, etc.) | | ≫o#y: White | |
| | 15. DECEOENT'S EDU | IUS Army 1984 | 16a. DECEDENT'S U | RUAL OCCUPATION | | 16b. KIND OF BUS | THE CO. (INC. LOTTER | | |
| | (Specify only highest grade Elementary/Secondary (0-12) | completed) | | rk done during most of working | | IGE. KIND OF BUS | HINESS/INDUSTRI | · | |
| 립 | 12 | College (1-4 or 5+) | Heavy Ed | uinment Oner | ator | Earth Ex | cavatio | n Contractor | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | neavy Eq | | | st, Middle, Malden | | in contractor | |
| ш | Harold B. Hamilt | on, Sr. | | Ge | orgia | R. Dick | ens | | |
| 0 8 | 19a. INFORMANT'S NAME (Type/Print) | | | OORESS (Street and Number of | | | | | |
| - | Charlotte A. Ham | | | ld Bay View | Road, | | | 21901 | |
| 1 1 | 20a. METHOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Rem | oval from Stata | etery cremetory or othe | oisposition (Name of place) | 1 | | CATION — City or | | |
| | 4 Donation 5 Office (Specify) | PENCEE | orth East | Methodist C | em. 1/ | 24 Nor | th East | . Maryland | |
| | 11/1/06 | 4/1-1 | | Crouch Fun | | | | | |
| | 110 car 7 | roud | | | | | | ast, MD 21901 | |
| | 23. PART i. Enter the diseesea, or ahock, or heert feliure. | complications that cause List only one cause on a | d the death. Do no ach line. | t enter the mode of dyin | g, auch ea c | cerdiec or reapi | ratory arrest, | Approximata interval Batween | |
| | IMMEDIATE CAUSE (Final disease or condition | 1 1 - | - | | | | | Onset and Death | |
| | a. Melcotatics Lung Canger DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | |
| z | DUE TO (UM AS A CONSEQUENCE OF): | | | | | | | | |
| 일 | Sequentially liet conditiona, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| CA | cause. Enter UNDERLYING CAUSE (Disease or injury | C | | | | | | | |
| 造 | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| CERTIFICATION | | d | | | | | | | |
| A | PART II. Other algnificent condition | na contributing to death b | ut not resulting in | the underlying ceuse gi | ven in Part i | . 24a, WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| 음 | - | | | | | 1 TYES 2 | | COMPLETION OF CAUSE OF DEATH? | |
| M | DID =001,000,1100 | | | | | | | 1 TYES 2 NO | |
| PHYSICIAN: MEDIC | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF | | ио □ | | | | |
| C | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PLACE OF DEA | | | | | |
| 14S | 1 TYES 2 5 NO | 1 Inpetient 2 ER/Out | 28b. TIME | OF 28c, INJURY AT | | Other (Specify) DESCRIBE HOW IF | HIDV COMPE | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJUI | | | DESCRIBE NOW IF | NJURY OCCURED | | |
| BY | 2 Accident Investigation 3 Suicide 6 Could not be | 26s. PLACE OF INJURY | — At home, farm, atr | | | LOCATION (Street a | and Number or Rur | al Route Number, | |
| TED | 4 Homicide determined | building, etc. (Spe | cify) | | (| City or Town, State) | | | |
| 12 | 29a. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of my know | ledge, death occurred | at the time, data and place, | and due to the | cause(a) and man | oner as stated. | | |
| COMPLET | | ER: On the basis of examination | | | | | | e(s) and manner as stated, | |
| ш | 295. SIGNATURE AND TITLE OF CERTIFIE | 9000/ | 1/1 | 29c. LICEN | ISE NUMBER | | 29d. DATE SIGN | ED (Month, Day, Year) | |
| TO B | Martha Huk | al Stuffy | K | C/00 | 1002 | 168 | > 1/ | 23/96 - | |
| F | 30. NAME AND ADDRESS OF PERSON WITH | | | | | | | 1 | |
| | Dr. M. Hosford-S | kapof, M.D., | 111 W. H | igh Street, | Suite | 202, E1 | kton, M | D 21921 | |
| | JAN 2 4 1996 | Allia Davilson | | | | | | | |
| | Jnii 44 1330 | James an american la | artall | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | Pages 1, 2, 3 should | |
|--|---|--|
| O THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and the filled within 72 hours after death with the State Dent, of Health and Mental Housene prior to burial cremation or removal | STANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event the medical examinar much he meditad as ence |
| - O | O THE | MPO |

TOWN E. GLAN ST. DATE FILED (MOTTH) POP 9 1996

12 REGISTERATE SIGNATURE
Falsa distribution hardelf

| | | | | | | | 91 | 0 03/2/ | | |
|----------------------|---|--|--|---------------------------------|---|--|-----------------------------|---|--|--|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF | HEALTH AND | MENTAL HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) FRANCES | М. | HERMA | СН | | 2. DATE OF DEATH HONTH FEB. 3, | 1996 | 3. TIME OF DEATH 12:45 A M | | |
| | 4. SOCIAL SECURITY NUMBER 578 – 07 – 2415 | 1 🗆 M 2 🔀 F | (In yrs. lest birthday) 86 YRS. | IF UNDER 1 YEAR | | T DATE OF BUREAU | | SHITTHPLACE (State or Foreign Country) ASHINGTON, D.C. | | |
| NO HO | 9a. FACILITY NAME (If not institution, give sta FRIENDS NURSING | | | | N OR LOCATION OF | DEATH | 9c, COUNT | Y OF DEATH TGOMERY | | |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE MARYLAND MONT | | Y, TOWN OR LO | CATION SPRING | | | 10d. INSIDE CITY LIMITS? | | | |
| FUNERAL (| 100. STREET AND NUMBER 2201 COLSTON DRIV | /E APT. 31 | | | 10f. ZIP CODE | 910 | | 1 TYES 2 NO N OF WHAT COUNTRY? ED STATES | | |
| BY FUNE | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2, NO | If yes, | DECENDENT OF HISP, specify Cuban, Mexic (ES 2 NO Specific | ANIC ORIGIN? (Specify Yecan, Puerto Ricen, etc.) | | I. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of v life. Do NOT us ACCOUN | vork done during e retired.) | ATION most of working | PUBLISE | | TRY | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) ROBERT | ROBERTS | | | 18. MOTHER'S N | IAME (First, Middle, Maiden STO | Surname) | erme) E R | | |
| TO B | 190. INFORMANT'S NAME (Types/Print) FRANCIS L. HERMACH, HUSBAND 190. MAILING ADDRESS (Street and Number of Rural Route Number, City of Town, Stena, Zip Code) 2201 COLSTON DR., APT. 311, SILVER SPRING, MD.20910 | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Gurlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE ANODATE OF DISPOSITION (Name of METROPOLITAN) 20c. LOCATION — City or Town, State METROPOLITAN 210b. PLACE ANODATE OF DISPOSITION (Name of METROPOLITAN) 210c. LOCATION — City or Town, State | | | | | | | | | |
| | ** MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MA | | | | | | | E 20882 | | |
| | 23. PART I. Enter the diseases, pr constant shock, pr heart failure. Limited in the constant shock is a second time. It is a second time is a second time. | omplications that caused list only one cause on a cause on a cause on a cause on a cause on a cause on a cause on a cause on a cause on a cause of the cause of t | ach line. | ot enter tha | node of dying, su | ch as cerdiec or resp | Iratory erres | Approximate interval Between Oneet and Death | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): MY MY DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART ii. Other significant conditions | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | |
| SICIAN: | | HOSPITAL: 1 Inpatient 2 ER/Outp | atient 3 DOA | OTHER: | PLACE OF DEATN (C | heck only one) 8 Other (Specify) | | | | |
| ВУ РНУ | 27. MANNER OF DEATH Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIMI | OF 28c. I | NJURY AT WORK? YES 2 NO | 28d. DESCRIBE HOW I | NJURY OCCUR | ŒD | | |
| ED | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, s | traet, fectory, of | fice | 281. LOCATION (Street City or Town, State) | and Number or | Rural Route Number, | | |
| COMPLET | | IAN: To the best of my knowl | | | | | | suse(s) end manner ee stated. | | |
| BEC | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NU | MBER | | GNED (Month, Day, Year) | | |
| 0 | term - Mar | and is | | | 12-25 | 747 | 1 | 2 1 | | |

ST SIEVER SPRING Md 2018

77/2-17/7/19/ 356 U.S.

| | | | | | Ce | ertificat | e of | Death | | Reg. No. | | | |
|-------------------------------|--|----------------|---|--|--------------------------------|----------------------|----------------|---------------------------|------------------------------------|-------------------------------|------------------|----------------------------|----------------|
| | Dharaia | ! | 1. Decedent'a Nama (First, Middla, L | ast) | | | | | 2. Date of D | Peath Day | Yaar | 3. Tim | ne of Death |
| | Physic /Medi | | Norman Ste | wart Heaney | | | | | Januar | | 1996 | | 3:30PM |
| | Exami | | 4a. Facility Name (If not institution, gi | | | | | 4b. City, Town, o | or Location of Dea | th 4c. (| County of Deet | h | |
| | | | Anne Arundel M | edical Center | | | | Annapol | | An | ne Aru | nde1 | |
| | Funeral | - | | Sax 7. Aga (In yrs | |) If Under Months | 1 Year Days | If Undar 24 H Hours M | | irth Day, Year) | 9. Birt | hpiaca (Ste | eta or Foreign |
| | Director | | 111-22-8967 | 82 | Yrs. | | | | Oct 9 | | | nsylv: | |
| 3 | Bug * | | Usuai Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or L | ocation | | | | | | 10d Ineld | de City Limits |
| ford | f sho | ō | | | | | | | | | 100 | | Yas 2 No |
| 4 | "hatural", or itema 23a or 28a-f show edeal Examiner must be notified at | Director | MD Anne Ar | undel | Anna | polis | Code | | | 10g. Citizen of What Country? | | | |
| 40,111 | | | | A | | 101. 24 | 0000 | 21/01 | | | | | |
| 400 | 22 2 | Funeral | 76 Shipwright S | 12. Was Decedent Ever in U | J.S. 13. | . Was Deced | lent of I | 21401 Hispanic Origin? | (Specify Yas or N | | ited Sta | | n. |
| , | The The | Fur | 1 ☐ Nevar Married 2 ☑ Married | Armed Forcas? 1 ☑ Yas 2 ☐ No | | | | | (Specify Yas or Narto Rican, etc.) | | Bleck, White | | |
| 7 | La Contraction | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Yeer or Dates: WWI | I | 1□ Yas | 2 XNo | Specify: | | | Specify: W | hite | |
| | Natural Inches | Completed | 15. Decedent's E | ducation | 16a. Deci | edent's Usua | i Occu | pation | un el de e | 16b. Kin | nd of Business/ | | |
| 1 | | ple | (Specify only highast gi Elementery/Secondary (0-12) | College (1-4or 5+) | lifa. | DO NOT us | sa retire | during most of w | vorking | | | | |
| | Hygien ther th | So | | 5 | Aut | o Exe | cut: | Lve | | Au | to Indi | ustry | |
| 1 | a da S | Be | 17. Father'a Name (First, Middla, Las | 1) | | | | 18. Mother's N | lame (First, Midd | e, Maidan S | Sumama) | | |
| chould | marked o | 2 | Frederick John | | 1 | | | | on MacMi | | | | |
| 200 | 2 - 2 | | 19e. Informent'a Name/Relationship | | | - | | | Rural Routa Num | | | | 0.1 |
| | Department of Heelth a important: If Nem 27 is any injury or other tra once. | | Marianna M. Hea | | | | | | Annapol | | | _ | |
| mit Done 1 av | 0 = 0 | | 1 ☐ Burial 2 ☐ Cremation 3 | | Piece of Disp cematary, cre | | | | Date | | cation - City or | | |
| 9 | tant: | | 4 Donation 5 Other (Spec | | | | | atory 1/ | | | twood, | _ | |
| | mpo my fr | | (2) Signature of Funeral Service Lice | 1 | / ' | 22. Name an | d Addre | osa of Facility Jo | hn M. Ta | ylor | Funera. | 1 Hom | e, Inc |
| | 10140 | | Small X | Sylor | 1 | .47 Du | ke o | of Glouc | ester St | . Ann | napolis | , MD | 21401 |
| | | | 23a. Part1. Enter the disease, or con shock, or heert feilure. Liat only | polications that caused the dea one ceuse on each line. | th. Do not er | nter the mod | e of dyl | ng, such es card | iec or respiratory | arrest, | | Approxi | Between |
| | hysician /Medicai | | Immediate Cause (Finai | , | | | | | | | 1 | Onset a | and Death |
| | xaminer | | diseasa or condition resulting in deeth) | e. Acute Ri | ght Pr | eumot | hora | ax | | | | 4 h | ours |
| | | 5 | | | or es a conse | | | | | | | | |
| 7 | nsit is | 듵 | | b. Placemen | _ | - 1 | c Fe | eeding T | lube | | | | |
| · Jane | physician end s the buriel-transit | Examiner | Sequentially list conditions, if any, leeding to Immediate | | or as e conse | | | | | | | 2 1.7 | eeks |
| ficate heav | sicial buri | | cause. Enter Underlying Cause (Disease or injury thet initiated events | Recent R | | | nıa | | | | | 2 W | eeks |
| | ing phy e es the | Medical | rasulting in death) Last | Due to (| or as a conse | quance or): | | | | | | | |
| the contract | ndin | | | d | | | | | | | - ! | | |
| # | ed by the attendir deteched for use | Physician/ | Pert II. Other significant conditions | contributing to death but not re- | suiting in the | underlying o | auee ch | ven in Port I | 23h Di | f tobacco i | uss contribute | to the cau | ene of death! |
| that the de | by the | hys | | | sexung in tho | andonying o | 2000 g. | vari in trotti. | | | No 3□P | | |
| | | by F | | | | | | | _ | | | | |
| ractilina | been signature that the should th | | | | | | | | | s en autops formed? | sy 24b. | Were autop avallable pr | pay findings |
| la val | JO 69 | piet | | | | | | | - | | | completion of deeth? | of causa |
| The | 2 - 0 | Completed | | | | | | | 10 | Yes 2X | 2 No | 1 ☐ Yea | 2□ No |
| 9 | certificate rector, pag | Be (| 25. Wes case referred to medical examiner? | | | | | 26. Place of D | eeth (Check only | ona) | | | |
| Physician: The law requires ? | this certific | 70 | 1 X Yes 2 No | Hospitel: 1 Department 2 C |] ER/Outpetie | ent 3 DO | A Oti | her: 4 Nursing | Home 5□Re | sidenca 6 | Other (Spe | city) | |
| | her th | | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28e. Date of Injury (Month, Day Year) | 28b. Time | of 2 | 8c. Inju Wo | ry at rk? | 28d. Describe | how Injury | occurred | | |
| Attending | or: A | atic | 2 ☐ Accident investigation | | | М | | Yes 2 □ No | | | | | |
| | after death. Director: After | Certification: | 3 Suicida 6 Could not t 4 Homicide determined | | oma, farm, a | treet, factory | , office | | | (Streat and | Number or Ru | ıral Route f | Vumber, |
| 5 | te de la la la la la la la la la la la la la | | | | | | | | | | | | |
| Hospital | t hour | edicai | | nysician: To the best of my knowing: On the basis of examina | | | | | | | | | se(s) |
| To the | within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Med | | and manner atated. | | | | | | | | | |
| P | 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2 | 286. Signature and title of certifier | | | 290 | | se number | | | a signed (Monti | | ir) |
| | | | Jon 1 | Journe | - | | אַדע | 3529 | | Janua | ry 29, | 1996 | |
| | | | 30. Name and eddress of person who | / \ | | | | | | | | | |
| | | | Jon B. Lowe, M. | | | e Anna | apo] | lis, MD | 21401 (4 | 10-22 | 4-0010 |) | |
| | Sta | _ | 31. Date filed (Month, Dey, Year) | 32. Registrer's Sign | ature . | 40 | | | | | | | |
| 16 | Registr | | JAN 30 19 | 96 The Same | ari anis | 4 | | | | | | | |
| HMH | 116 Rev 6/9 | 5 | | • | | | | | | | | | |

PROTECTION OF STREET FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| AL DR ALLENDING PRINCIPAL THE IZW TEQUIES THAT HE DEATH LETURATE OF EXECUTED WITH | AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pag | j |
| ₹ | AL | 8 |

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR Maurice Huff Jan. 11:59 Luther 1996 a 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 D F YRS. 74 Nov. 9,1921 212-18-1849 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 140 Grant Street Grantsville Garrett 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 NO Maryland Garrett Grantsville use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 140 Grant Street 21536 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—It yes, specify Cuben, Mexicon, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married 1 YES 2 NO Specify BY 3 Widowed 4 Divorced White TATAT ETED. 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) ě Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Banking should be detached Branch Manager once. 17. FATNER'S NAME (First, Middle Last) 18. MOTNER'S NAME (First, Middle, Meiden Sumame) Ħ Ira Huff Alice Guinn notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 140 Grant St., P.O. Box 141; Grantsville, <u>Anna Marie Huff</u> pe 20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Yown, State must 1 X Buriel 2 Cremation 3 Removal from State
4 Donetion 8 Other (Specify) Grantsville Cemetery Jan. 27 Grantsville, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Newman funeral Homes, P.A. Ruman Grantsville, Maryland 21536 medical 23. PART I. Enter the dramases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximats interval Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition the Ventricular Arrhythmia, Acute resulting in death) Sudden event, DUE TO (OR AS A CONSEQUENCE OF): Ischemic Heart Disease Sev. Years other traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Arteriosclerotic Cardio-Vascular Disease Unknown CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST 6 Injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO shows any COMPLETION OF CAUSE DF DEATN? 1 TES TO NO t - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NOXY UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one Hem HOSPITAL: OTHER: 1X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Nome XX Residence 8 ☐ Other (Specify) 0 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK?
1 YES 2 NO 27. MANNER OF DEATH 28d, DESCRIBE NOW INJURY OCCURED is marked. 5 Pending Investigation XX Natural BY 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) COMPLETED 6 Could not be 4 Nomicide 28 item 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. (Check only one) 2 😾 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner se stated. WURE AND TITLE OF CENTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 eig flon D 05658 January 26, 1996

502 E. Oak Street, Oakland, Maryland 21550

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

12 RESTRAR'S SIGNOURS

Herbert H. Leighton, M.D.,

JAN 2 9 1996

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1.1

iz .

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

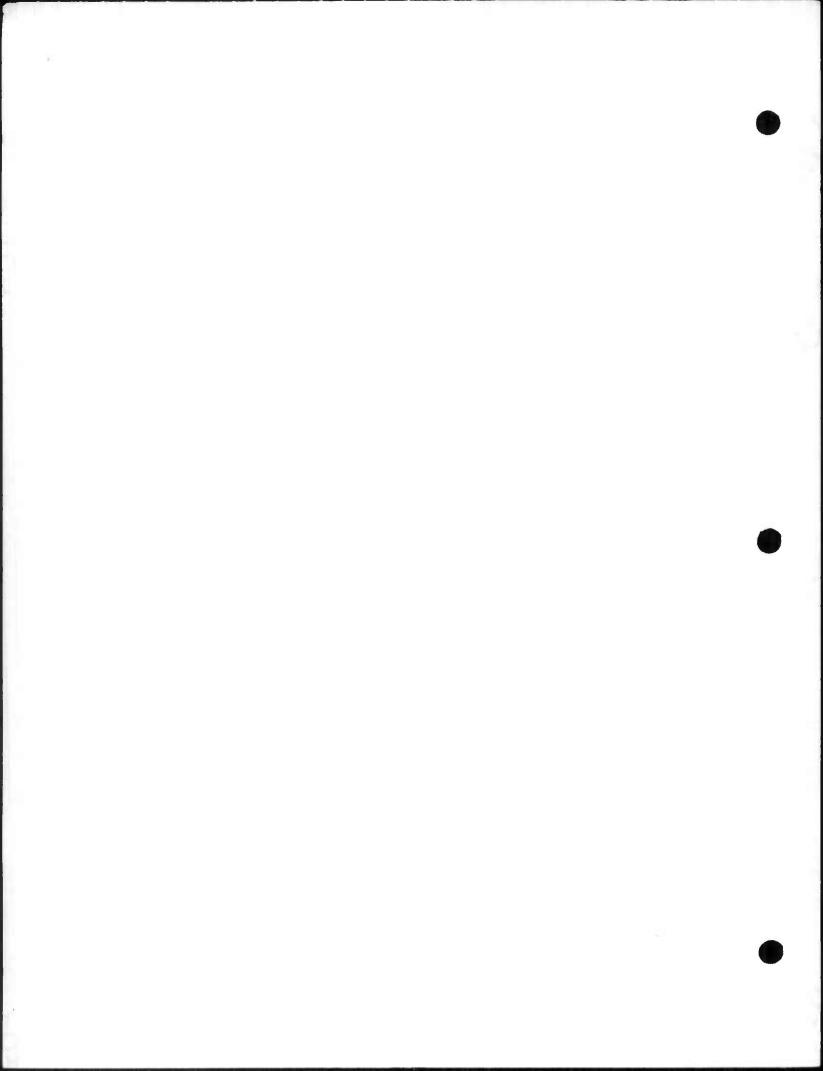
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | | | 3. TIME OF DEATH | | | | |
|---------------------------------------|--|--------------------------------|---|---------------------|-------------------|----------------------|------------|--------------------------|-------------------------------|--|----------------------------|---|------------------|--|--|--|
| | MYRTLE | DUDLE | Y HAYS | | | | | | | Janu | | 7,19 | 96 | 1915- pm | | |
| | 4. SOCIAL SECURITY NUM | BER | 5. SEX | 6. AGE (In y | yrs. last birthda | | DER 1 YEAR | | R 24 HRS. | 7. DATE O | F BURTH | - 13 | 8. BIRTH | IPLACE (State or Foreign | | |
| | 212-01-9736 | 76 | YRS | MONTH | B DAYS | HOURS | MIN. | Augus | Day, Year) | 1919 | Ma | ryland | | | | |
| | 9a. FACILITY NAME (If not in | | | 9b. C | ITY, TOWN | OR LOCAT | ION OF D | | | _ | INTY OF D | 4 | | | | |
| OR | 54 N. Cannon Ave. | | | | | H | agers | stown | | | | Wasi | hingt | con | | |
| 5 | RESIDENCE OF DEC | | | | | | | | | | | LACE (State of Foreign yland ATH ON Tod. INSIDE CITY LIMITS? IN YES 2 NO IAT COUNTRY? — American Indian, White White American Indian, White The aryland Approximate Interval Between Onset and Death In Yere Autropsy Findings Mail Able Prior To Were Autropsy Findings Mail Able Prior To | | | | |
| DIRECTOR | Maryland | Wach: | ington | | | - | N OR LOC | | | | | | | 10d. INSIDE CITY LIMITS? | | |
| | 10a. STREET AND NUMBER | | ington | | H | ager | stown | | | | | r | | 1 X YES 2 NO | | |
| FUNERAL | 54 North | | 7,170 | | | | ۱, | 01. ZIP COI | 111 | | | | | VHAT COUNTRY? | | |
| R | 11. MARITAL STATUS | carmon | 12. WAS DECEDEN | T EVER MILL | 0 40450 | | | 2174 | _ | | | | 5.A. | | | |
| | 1 Never Married 2 | Married | FORCES? 1 | YES : | 2 NO | | If yes, s | pecify Cub | en, Mexica | NIC ORIGIN? In, Puerto Ri | (Specify Yea can, etc.) | or No- | Black | k, White, etc. | | |
| B | 3 Widowed 4 Divo | becord | IF TES, GIVE W | MH UH DAIE | :5 | | 1 [] YE | S 2 🙀 NO | Specif | у: | | | Spec | White | | |
| COMPLETED | 15. DEC | EDENT'S EDUC | CATION | 16 | a. DECEDENT | | | | | 16b. I | IND OF BUS | SINESS/IN | DUSTRY | mirco | | |
| | Elementary/Secondary (6 | | College (1-4 or 5 | | Iffe. Do NO | use retire | , | | | | | | | | | |
| M M | 8 years | | | S | Shippi | ng Si | uperv | 7isor | | | Ribbo | n Cor | npany | 7 | | |
| 8 | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18. MO | THER'S NA | ME (First, Mi | ldle, Melden | Surname) | | | | |
| H | John | | | Dudl | .ey | | | Pe | arl | | | | Benr | nett | | |
| 2 | 19a. INFORMANT'S NAME (| | | | | | | | | | | | Stere, Zip Code) | | | |
| | Ronald Leon | | | | 32 5 | 5. L | ocust | St. | Hag | ersto | vn, Mo | d. 2 | 1740 | | | |
| | 20e. METHOD OF DISPOSIT | on 3 🗆 Remo | oval from State | | ry, crematory of | | | lame of | | DATE | 20c. LO | CATION — | City or To | wn, State | | |
| | 4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA | 1.7 | | Ros | e Hil | <u>Cer</u> | meter | | | | Hage | ersto | own, N | Maryland | | |
| | 21. SIGNATURE OF FUNERA | IL SENVICE LIC | ENSEE | | | 1 | 22. NAME | | | | | - 7 TT. | | | | |
| | 23. PART I. Enter the d | dos | VLI | 241 | | | 1221 | Fac | town | iery 1 | Mond | hh he | ~~~ | torm Md | | |
| NO | IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to lon as a consequence of: Due to lon as a consequence of: Due to lon as a consequence of: | | | | | | | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| | PART II. Other algolfice | nt condition | contributing to | death but | not reaultin | g in the | underlyli | ng ceuse | given in | Part I. 2 | 4a. WAS AN | | 24b | . WERE AUTOPSY FINDINGS | | |
| MEDICAL | | | | | | | | | | | PERFORMED? | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| 밀 | | | | | | | | | | _ | 123 2 | - NO | | | | |
| - 1 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | | | | | |
| N I | 25. WAS CASE REFERRED TO EXAMINER? | | | | PLACE OF D | | | | | | | - | | | | |
| ĭš | 1 YES 2 NO | | HOSPITAL: | ER/Outpatia | int 3 🗆 DOA | OTH 4 🗆 N | | ma 5 61-A | esidence | 8 🗆 Other (| Specify) | | | | | |
| BY PHYSICIAN: | | Pending Investigation | 28e. DATE OF (Month, Di | INJURY ay, Year) | | IME OF NJURY M | W | JURY AT ORK? YES 2 | □ NO | 28d. DESC | RIBE HOW II | NJURY OC | CURED | | | |
| | 3 Suicide 8 Homicide | F INJURY — . etc. (Specify) | At home, fern | ı, street, f | actory, offi | ca | | 281. LOCAT City or | ION (Street a Town, State) | ON (Street and Number or Rural Route Number, lown, State) | | | | | | |
| COMPLETED | | | CIAN: To the best of R: On the bests of as | | | | | | | | | | |) and manner as stated. | | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Morith, Day, Year) 106040 1-44- | | | | | | | | | | | | | | | |
| | 30. NAME AND ADDRESS OF | PERSON WHO | Hert M | 1-R | (ITEM 27) (Ty | pe, Print) | his | no | 1601 | land | 4 | 1457 | In, | hel nex | | |
| JAN 3 0 1996 ALL DREGISTRAN SIGNATURE | | | | | | | | | (| | | CP | | | | |



3. TIME OF DEATH

YEAR

REG. NO.

BALTIMORE, MARYLAND 21215-0020

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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| DIVISION OF | An avventue Dangerelast. The last required that the decade |
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2. DATE OF DEATH DAY 3:00 P. HENRY HERBERT HEROLD January 28 1996 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🖾 M 2 🗌 F 72 098-14-2491 Dec. 12, New York Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 17030 Oakleigh Way Hagerstown Washington DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 TES ZY NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 17030 Oakleigh Way 21740 United States as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 A YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married 1 YES 2 NO Specify: Spec#y: White BY 3 Widowed 4 Divorced World War II ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY nse (Specify only high page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) Foreman Pharmaceutical COMPL 10 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Charles Herold Regina Kull ह notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Adele M. Herold 17030 Oakleigh Way, Hagerstown, Maryland 21740 9 20g, METHOD OF DISPOSITION
1 🕒 Burlel 2 🗆 Cremetton 3 🗆 Removal from State
4 🗆 Donation 5 🗀 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE examiner must filled in by the funeral director, on. or removal. Green awn Memorial Park 1-31-96 Williamsport, Maryland 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Fred Lo Vistal 415 E. Wilson Blvd., Hagerstown, Maryland medical 23. PART I. Enter the disesses, or complications that caused the desih. Do not enter the mode of dying, such sa cardiac or respiratory arrest, ahock, pr heart failure. Liet only pne cause pn each line. Interval Batween Onset and Death IMMEDIATE CAUSE (Final other traumatic event, the disease or condition cremation. Fibrillation and completely fi burial, cremation ntri cular resulting in death) MinuTes DUE TO (OR AS A CONSEQUENCE OF and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the atten PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Signed by the Health and Diapetes PERFORMED? AWAIL ABLE PRIOR TO any pertension, COMPLETION OF CAUSE OF DEATH? 1 TYES 2 1 Shows Lyne 1 YES 2 NO Deen . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 has be Dept. 26. PLACE DF DEATH (Check only one) 25. WAS CASE DEFERRED TO MEDICAL Item certificate to the State EXAMINER? HOSPITAL OTHER: ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 5 the 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with t marked, 1 Natural 5 Pending investigation 1 YES 2 NO BY DIRECTOR: After the hours after death vitem 28 is mari 2 Accident 26a. PLACE OF INJURY — At home, ferm, streat, factory, offica building, stc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide hours a Hem 8 29a. CERTIFIER

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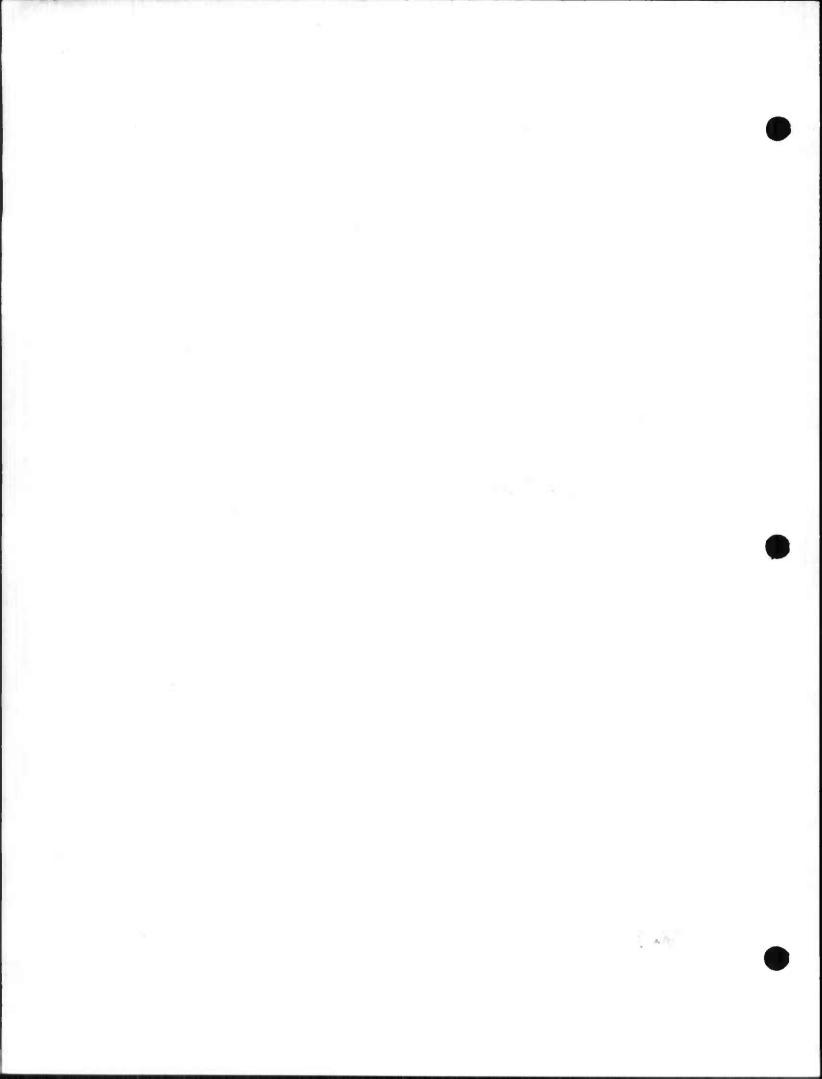
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(C TO THE HOSPITAL TO THE FUNERAL (be filed within 72 h EDICAL EXAMINERAD in the besie of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D11133 Jan 29 nencer 1996 2 30. NAME AND ADDRESS OF TENEON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 32. REGISTRAR'S SIGNATURE SPENCER, M.D. С. 1198 Kenly Avenue, Hagerstown, MD 21740

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director; page 5 should be detached for use as the burial-transit narmit Panes 1 2 should | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIEN REG. NO. | E | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last | | | | | 2. DATE OF DEATH MONTH DA | v v | 3. TIME OF DEATH | | |
| | MARY LEV 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Jan 27 | _ 19 | 96 4 110 P. | | |
| | 214-07-8319 9a. FACILITY NAME (If not institution, give | 1 - M 2 XF 8 | 2 YRS. | IONTHS DAYS | HOURS MIN. | FEB. 2, 191 | .3 1 | BIRTHPLACE (State or Foreign Country) MARYLAND | | |
| TOR | WILLIAM HILL N | | | R LOCATION OF DI | EATH | DORCHESTER | | | | |
| DIRECTOR | 10e. STATE 10b. COUN MARYLAND TAI | | TOWN OR LOCAT | ION | | | 16d. INSIDE CITY LIMITS? 1 XYES 2 NO | | | |
| 3AL | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT | | | | | | | | | |
| FUNERAL | 213 S. MORRI | S ST. | NII O ADMED | 21654 | | | | USA | | |
| BY | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES | 2 X NO | It yes, sp | ecity Cuben, Maxica 2X NO Specifi | NIC ORIGIN? (Specify Yes in, Puarto Rican, etc.) | or No- 14 | I. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) | UCATION de completed) Collège (1-4 or 5 +) | 16a. DECEDENT'S U: (Give kind of wo life. Do NOT use | DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUS | | | | TRY | | |
| MPL | 12 | | HC | MEMAKI | ER | OWN | HOME | | | |
| S | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Malden | | | | |
| E E | EDGAR R. LEWI | .S, SR. | 19h MAII ING A | DDDESS (Stanton | | DYS DASHI Route Number, City or Town | | | | |
| 임 | DOUGLAS HANKS, | JR. | | | | ORD, MD 2 | | ode) | | |
| | 20a. METHOD OF DISPOSITION | 200 | PLACE AND DATE OF | DISPOSITION (Na | me of | | | y or Town, Stata | | |
| | 1 Guriet 2 Cremation 3 Res 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L | | ALISBURY | | | | ISBU | RY, MD | | |
| | R W H | - Physipm; | OFID | NEWN A | M FUNE | RAL HOME, | P.A. | | | |
| \dashv | 23. PART I. Enter the diseases, or | | | 200 5 | HARR | ISON ST., | EAS | TON, MD | | |
| | IMMEDIATE CAUSE (Finel | List only one cause on a | ach line. | _ | | n as cardiac or reapi | atory arrest | t, Approximate Interval Between Onset and Death | | |
| | disease or condition resulting in death) a. / Leimen / Sease / Leimen / Sease / Leine | | | | | | | | | |
| z | | | | | | | | | | |
| HILLAIION | d any, leading to immediate ausse. Enter UNDERLYING | | | | | | | | | |
| 2 | CAUSE (Disease or Injury that initiated events | c. DUE TO (OR AS / | CONSEQUENCE OF: | | | | | | | |
| = | resulting in death) LAST | d | 141-140-140-14 | | | | | į | | |
| AL CE | PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS | | | | | | | | | |
| | | PERFORMED? AMA | | | | | | | | |
| MEDIC | | | | | | 1 YES 2' | 7 110 | OF DEATH? | | |
| ž | DID TOBACCO USE CONT | | | | UNCERTAIN | V 🗆 | | 101 | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | | | | | | |
| 1 | 27. MANNER OF DEATH | 1 Inpetient 2 ER/Outp | 28b. TIME (| OF 28c. INJI | JRY AT | 8 Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCUR | NED. | | |
| 10 | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUF | | RK? ES 2 NO | | | | | |
| ED | A D Bulates — | 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, term, atreet, factory, office building, etc. (Specify) | | | | | | | | |
| MFLE | 29a. CERTIFIER (Check only | SICIAN: To the best of my know | iedga, death occurred | at the time, data | and place, and due | to the ceuse(s) and mane | ner as stated, | | | |
| ٥ | | ER: On the basis of examination | | | | | | ause(s) and manner as stated. | | |
| N N | 296. SIGNATURE AND TITLE OF CENTIFIE | 7 / 1 | - 1- | b | 29c. LICENSE NUM | P) 06 | 29d. DATE SI | IGNED (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS AT PERSON W | NO COMPLETED CAMES OF DE | ATH (ITEM 27) (Type, Pr | int) | 1) 0 | 2 | 00 | in 22,1776 | | |
| | Edward J. M | achanghlin | 4/ | Lirora | St. C | Pambridge | Ma | 1 21613 | | |
| | JAN 24 1996 | 32 REGISTRAR'S SIGN. | ATURE | | | | | | | |

filled in by the funeral director, page 5 should be detached for ion, or removal.

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attending physician and mtal Hygiene prior to bur

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executed burial

8 certificate

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ATTENDING PHYSICIAN:

JAN 23 1996

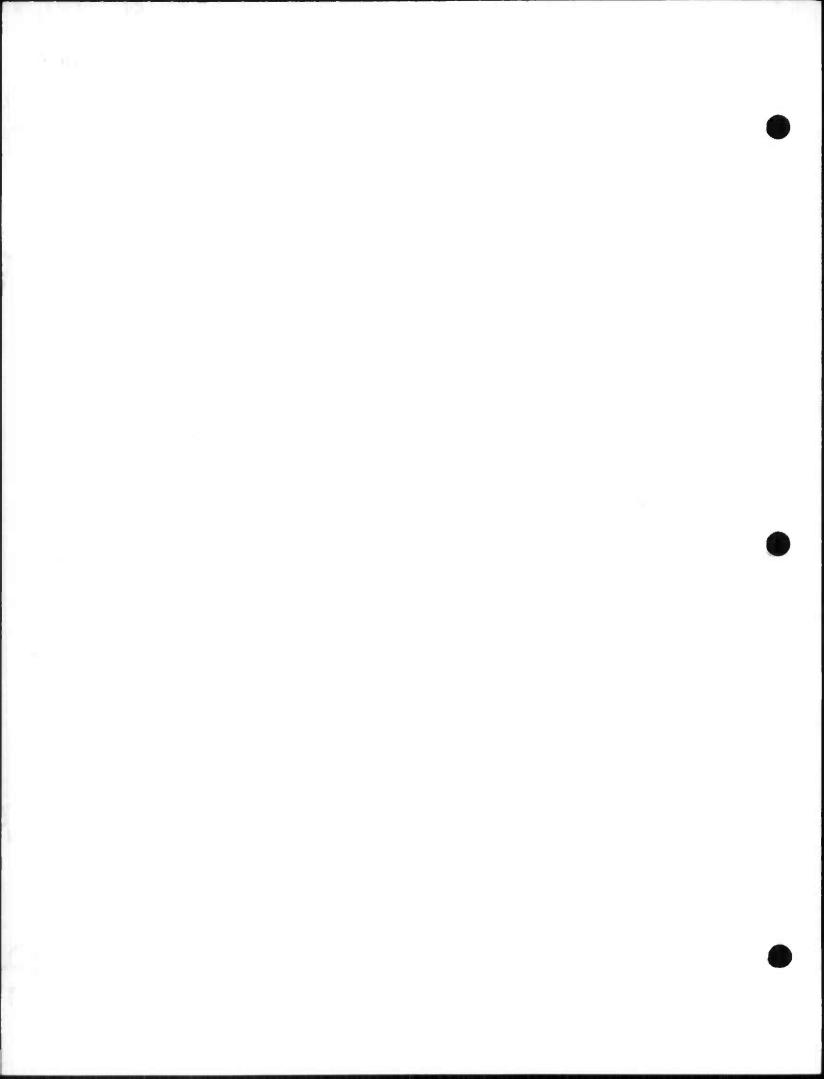
use as the burial-transit permit. Pages 1, 2, 3 should

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR RUIH LOUISE GITH HIGGINS JANUARY 18 1996 7:25P. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH
(Morth, Day, Year)
April 9, 1900 8. BIRTNPLACE (State or Foreign 215-36-1744A 1 M 2 F DAYS HOURS Maryland 9e. FACILITY NAME (If not inetitution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATN DIRECTOR Meridian Center-The Pines Easton Talbot RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Talbot Neavitt 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 6398 Duck Cove Lane 21652 USA WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced If yes, specify Cuban, Mexican, Pt.

1 YES 2 NO Specify: В Specify: White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Housewi fe 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ George Gith Lena Matthews BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William E. Higgins P. O. Box 173, Neavitt, Maryland 21652 ě 20a, METNOD OF DISPOSITION
1 X Burlet 2 Cremetion 3 Ref
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Woodlawn Memorial Park 1/22/96 Easton, Maryland examiner 21. SIGNATURE OF, FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harrison E. Leonard Funeral Home MADON 312 S. Talbot St., St. Michaels, MD 21663 medical 23. PART I. Enter the disesses, or complications that caused the death. Do not anter the mode of dying, such as cardisc or respiratory arrest, shock, or haert failura. List only Dna ceuse on each line. Interval Between **IMMEDIATE CAUSE (Final Onset and Death** the disesse or condition HONIC OBSTRUCTIVE YULMONARY DISTAGE VEARS resulting in death) traumatic event, TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST 0 After this certificate has been signed by the atter death with the State Dept. of Health and Mental is marked, or item 23 shows any Injury, o PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE HRONIC ANEMIA 1 YES 2 NO 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA me 5 Residence 6 Other (Specify) 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d. OEŞCRIBE HOW INJURY OCCURED 1 XNatural 5 Pending 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: If Item 2 29a. CERTIFIER
(Check only one)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(a) and menner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 26350 96 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) William S. Bremer M.D. 800 S. Talbot St. St. Michaels, Md. 21663 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Jahr Drucker Reveall



Please Type or Print in Black Indelible Ink. Assure All Copies Are I salble State of Maryland / Department of Health and Mental Hygiene Q.S.

| | | | | rate of wi | aryiaria / i | Certificate of | | | g. No. | 03/34 |
|-----------------|--|----------------|--|--|----------------------------|--|--|---|-----------------------------------|--|
| | | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Dete of Death | | 3. Time of Death |
| | Physici /Medic | | AGNES | Ε. | | Hadd | away | Jan. 20 | Day 1996 | 5:18 PM |
| | Examir | | 4a. Fecility Neme (If not institution, give stre | et and number) | | | 4b. City, Town, or Location of Deeth 4c. County of Deeth | | | |
| | | | Memorial Hospita 5. Social Security Number 6. Sex | | ston e (In yrs. lest bi | rthdev) If Under 1 Year | Easton If Under 24 Hrs. | | Talb | |
| ġ. | Funeral Director | | | 2 LF | 83 | Yrs. Months Days | Hours Min. | 8. Dete of Birth (Month, Dey, JUNE 13 | ,1912 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | e Maryland Sa-f show roffed at | | 10e. State 10b. County | | 10c. City, Tow | n or Location | | | | 10d. Inaide City Limits |
| | | ctor | MARYLAND TALI | ЗОТ | TII | LGHMAN | | | | 1 Tyes 2 □ No |
| | vith th | Director | 10e. Street end Number | | | 10f. Zip Code | | 10 | g. Citizen ot Wh | nat Country? |
| | 23e | eral | 21477 ELMER STRI | | | 216 | | | USA | |
| 21215-0020 | swithin 72 hours after death with the Maryland liene. Then "naturel", or items 23s or 28s-f show the Madical Event for must be notified at | by Funeral | 11. Maritei Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced | Wes Decedent I Armed Forces? 1 ☐ Yes 2 1 I If Yes, Give Yeer or Dates: | | 13. Was Decedent of I If Yes, specify Cub | dispanic Origin? (S en, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | | - American Indian, White, etc. WHITE |
| 15-0 | 72 h | Completed | 15. Decedent's Educat (Specify only highest grade of | on om <i>pieted)</i> | 16a | Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire | pation during most of wor | king 1 | 6b. Kind of Busi | iness/Industry |
| 121 | within sne. then | dmi | Elementary/Secondary (0-12) | College (1-4or 5 | | | d) | | OLIN | HOME |
| | Hygi Her in | | 17. Father's Neme (First, Middle, Last) | | , | HOUSEWIFE | 18. Mother's Nan | ne (First, Middle, M | | HOME |
| /ian | e g a a | To Be | JAMES M. PENTZ | | | | BESSIE | M. CUM | MINGS | |
| , Maryland | es 1 and 2 of Health a f item 27 is | | 19a. Informant's Name/Relationship (Type, CHESTER R. HADD) | | | . Mailing Address (Street BO5 TILGHM | | | | |
| Baitimore, | | | 20a. Method of Disposition ↑♥Qurlai 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | ovai from Stete | cemete | f Disposition (Name of ry, cremetory or other pie HMAN CEMET | | | oc. Location - C | ity or Town, State |
| Sait | permit. Pag Department Important: I eny injury o | | 21. Signeture of Funeral Service Licensee | | | 22. Name end Addre | | | | |
| ш_ | 20559 | | JOHN R. ME | RCERO | 2 CFS | NEWNAM F | UNERAL | HOME, P | A. ASTON | MD |
| | Physician /Medical Examiner Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): The property of the property | | | | | | | Onset and Death | | |
| 7 | /Medical Examiner | | Immediate Ceuse (Final disease or condition | Thron | ie oh | tructive | pulmo | nary D | 1Sease | Years |
| | ZXUIIIII | 4 | resulting in death) a. | | Due to (or as a | consequence of); | | | | |
| | uted d ansit | Examiner | b | | | | 4 V) | | | 1 |
| o, | an and rial-tra | | Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying | consequence of): | | | | | | |
| x 68760, | entificate be executed ding physician and se as the burlal-transit | /Medical | Celuse (Disease of injury that initialed events resulting in death) Last Due to (or as a consequence of): | | | | | | | |
| Вох | the death certify y the attending y the attending | Physician/M | Day II. Other classificant can different in II. | | | A December 11 Annual Control | | | | i |
| 0 | - 0 - | hys | Pert II. Other significant conditions contrib | | - | | en in Pert t. | 23b. Did tob | | ribute to the cause of death? |
| S, D | igned b | Бу | Avema | | | | | | 20100 | Trobably 4 officion |
| of Vital Record | been should | Completed | Avema Hypertension Congestive 25. Was case referred to medical | | | | | 24e. Wes an performe | | 24b. Were autopsy tindings available prior to completion of cause of death? |
| E E | 0 - 0 | Com | Congestive | Hear. | + Fa | ilure | | 1 🗆 Yes | 3 KNO | 1 Yes 20 No |
| /ita | ysician: The | Be | | | | | | th (Check only one, |) | |
| of | 5 00 | 1 | 1 ☐ Yes 25 No Hosi | 1 Donpatie | | tpatient 3 DOA Oth | 4 LI Nursing H | ome 5 Residen | | |
| on | of or Attending P after death. I Director: After d in by the funer | tlon | Naturei 5 ☐ Pending | 6a. Date of Injur (Month, Day | Year) 28b. | Fime ot 28c. Injury Wo | yat rk? Yes 2 □ No | 28d. Describe how | injury occurred | 1 |
| Division | after death Director: In by the | Ifica | 3 Suicide 6 Could not be | 8e. Piece of fnju | ry - At home, fe | rm, street, factory, office | 700 2 2 110 | | | or Rurel Route Number, |
| ā | s afte | Certification: | 4 Homicide | building, etc | . (Specify) | | | City or Town, | Stete) | |
| | To the Hospital or Attanding Physicial within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral | edical | 29e. Certifier (Check only one) Certifying Physicia 2 Medical Examiner: | n: To the best of On the basis of end manner sta | examinetion an | , death occurred et the ti d/or investigation, in my o | me, dete and place pinion, deeth occur | and due to the cau | se(s) and manr e end piace, an | ner as stated. d due to the cause(s) |
| | To the Comit | × | 29b. Signeture and title of certifier | 1. | | 29c. Licens | | 296 | d. Date signed | (Month, Day, Year) |
| | | | muchael 1 | 000 | MD | W | 12005 | | 01/ | 21116 |
| | | | 30. Name and eddress of person who comp MICHAEL LEES, N | | | | ANE, EA | STON, M | D 2160 | 1 |
| | Star Registra | | JAN 22 1996 | 32. Registra | r's Signature | arlall | | | | |

after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 SUNC OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL

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| DIRECTOR: After this certificate t | after | 28 |
| DIRE | hours | Item |
| ERAL | filed within 72 hours after death with the State Dept. of Health and Mental Hygiene pr | PORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medic |
| FUN | with | TAN |
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BOGRAKOS

32. REGISTRAR'S SIGNATURE

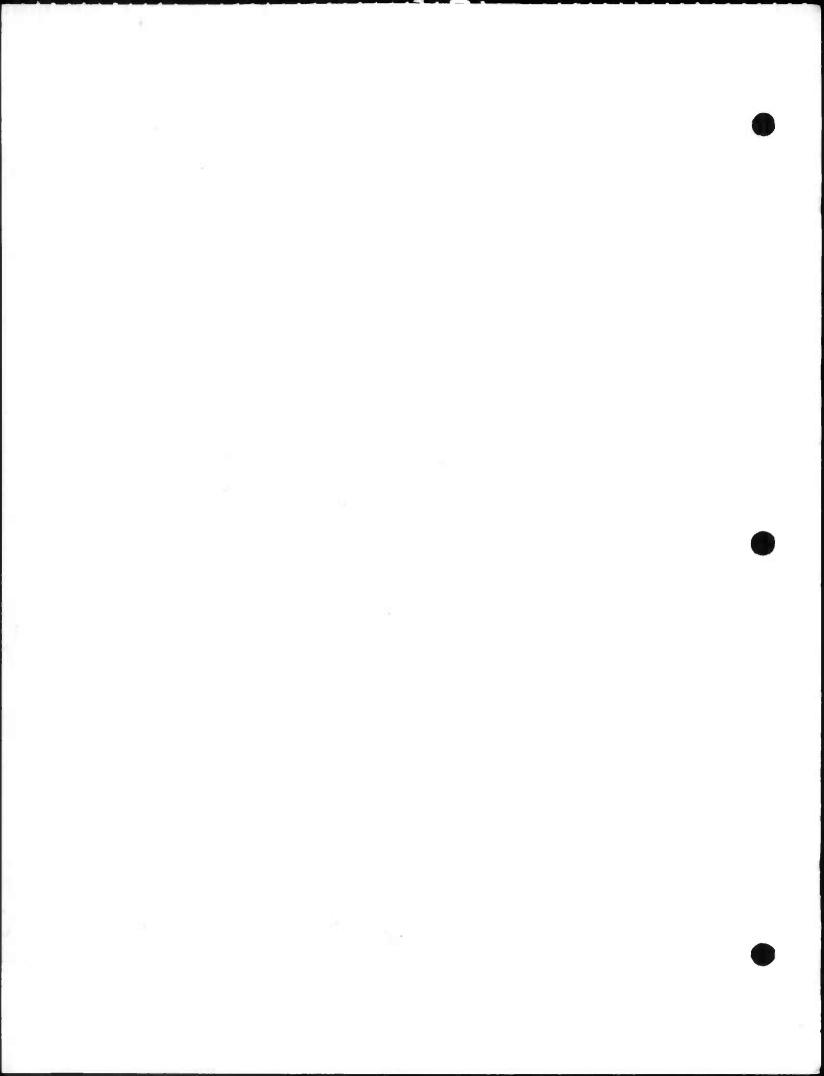
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 28, DORIS S. HEIDEL 1996 2:00 A. Jan. 14 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birtnday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign Dec. 7, DAYS HOURS 1 M 2 X F 74 216-12-1215 YRS. Virginia 1921 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 404 E. Pine St. Delmar Wicomico RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Delmar Md. Wicomico 1X YES 2 NO 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 404 E. Pine St. 21875 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ᡬNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: 3 X Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high intary/Secondary (0-12) 9 Homemaker Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Archie Poulson Gertrude Poulson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue E. Weber 603 Grove St. Delmar, De. 19940 20a. METHOD OF DISPOSITION
1 XBuriel 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE ery, crematory or other place)
Stephens Cemetery 1 - 304 Donation 5 Other (Specify) Delmar, De. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Wellenia Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Approximate** Interval Between 0200 IMMEDIATE CAUSE (Final **Onaet and Death** disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) HTN Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease Dr Injury that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 70 OF DEATN? 1 - YES 2 - 40 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** OTHER: 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26b. TIME OF 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO 28 JAN 96 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Could not be 4 Nomicide 29s. CERTIFIER

(Check only CERTIFYING PNYSICIAN: Totale best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) NH BYBY 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type Print) P MAL

XOE

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

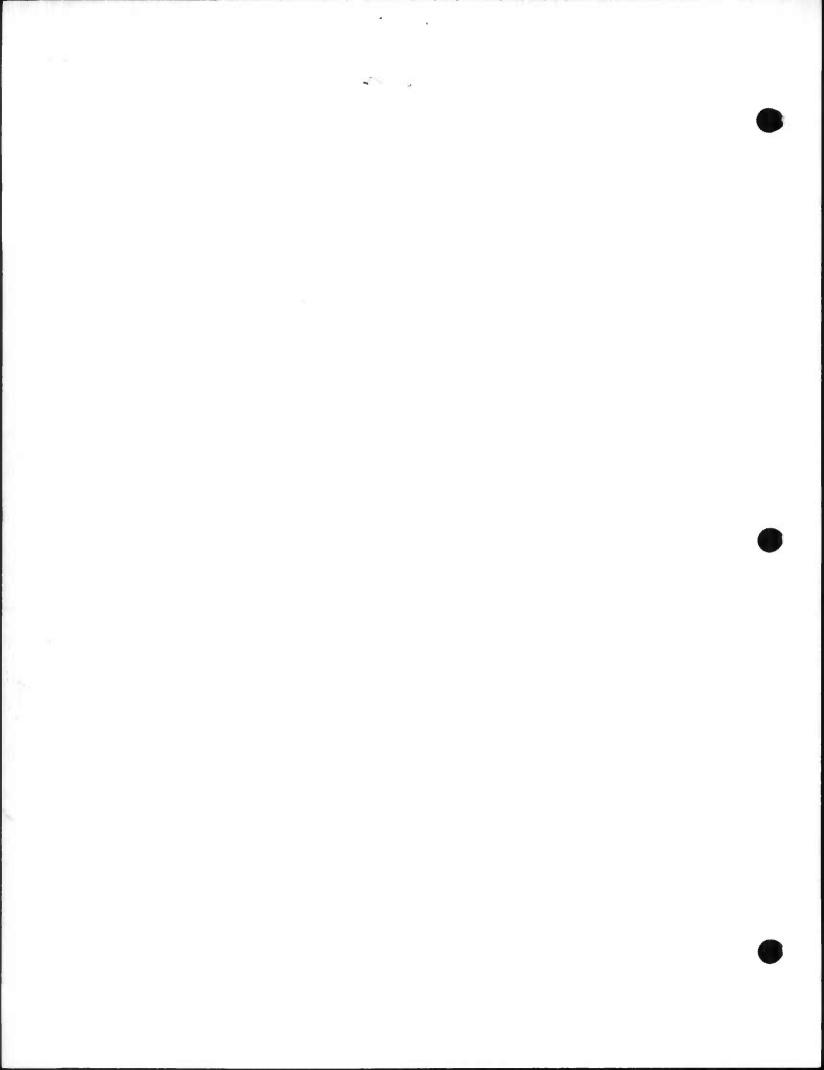
IMPORTANT: If Item 28 is marked, or Item 23 shows any Initury, or other frammatic manner.

| | | | | | | | | | | (| 36 | 03736 |
|---|--|--|--------------------|-----------------------|------------------------------|-------------------------------------|----------|----------|--|----------------------|----------------|--|
| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND C | DEPAR | RIMENT | OF HEAD | LTH A | AND W | IENTAL HYGII | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | T | 2. DATE OF GEATH | | | 3. TIME OF OEATH |
| | Helen C. Hi | ighes | thes | | | | | January | 28, 1 | 996 | 7:30 p | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. In | st birthday) | IF UNDER 1 | | UNDER 24 | | 7. DATE OF BIRTH (Month, Day, Year) | | | HPLACE (State or Foreign |
| | 220-01-0787 | 1 □ M 2 🔯 F | 90 | YRS. | WONTHS | DAYS HOL | URS | MIN. | May 12. | | | nsylvania |
| | 9n, FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY, | TOWN OR LO | CATION | | | | UNTY OF | |
| P | 301 Custis Stree | et | | | Abe | erdeer | 1 | | | 4.7 | Harf | ord |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | v | | 1 40 - 017 | Y. TOWN OR | | | | | | | |
| E E | | | | ioc. Cri | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland 100. STREET AND NUMBER | Harford | | Ц | Abero | | | | | | | 1 X YES 2 NO |
| FUNERAL | | | | | | 10f. ZtP | 1.54 | | | | | WHAT COUNTRY? |
| 빌 | 301 Custis Stree | | | | | | 2100 | | | | U.S. | |
| B | 1 Never Merried 2 Merried 3 X Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 W | RMED NO | 17 | AS DECENDE yes, specify YES 2 3 | Cuban, | Mexican. | offy: Specify: | | | E — American Indian, k, White, etc. hit: |
| | 15. DECEDENT'S EDU (Specify only highest grade | | 16a, Di | ECEDENT'S | USUAL OCC | CUPATION | | | 16b, KINO OF I | BUSINESS/H | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | B. Do NOT u | work done du se retired.) | iring most of v | working | | | | | |
| MP | UNK | 0 | 1 | Homen | aker | | | | In ho | me | | |
| Ö | 17. FATHER'S NAME (First, Middle, Lest) | | | | | 18. | MOTHE | R'S NAM | E (First, Middle, Maid | | | 4.2 |
| BE (| William E. Cresn | ner | | | | _ [| E | Bess | ie Jane | Heaps | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS (| Street and Nu | | | oute Number, City or | | | |
| F | Mrs. Norma Dubre | ee | | 301 | Custi | is Str | eet | . A | berdeen, | Mary | land | 21001 |
| | 20s. METHOD OF DISPOSITION 1/2/Buriel 2 Cremation 3 Rem | and to a Otal | 20b. PLACE | ANDDATE | OF DISPOSIT | ION (Name of | - | | | LOCATION - | | |
| | 4 Donation 8 Other (Specify) | IOVAI TIOIII STATE | Bel A | emetory or o ir M⊖ | ther place) MOL1 3 | al Gar | den | ns | 1/31 Be | l Air | . Man | rvland |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | 22. N | AME ANO AD | DRESS | OF FACI | LITY | | | |
| | Donu & d |): M: 01 | hearmi |) | | | | | Funeral yland 2 | | | A. |
| | 23. PART I. Enter the diseases, or | eomplications the | t ceused the de | eath. Do i | not entar ti | he mods of | f dying | a. auch | as cardiac or rea | plratory s | 3399 crest. | Approximata |
| | snock(or nesrt failure. | List only one cau | ise on each line | 0. | 0 | . / | , | 1 | | | , | Interval Betwee |
| | IMMEDIATE CAUSE (Final disease or condition | Con | agatui | o fo | an S | 1+ | Teb. | lev | 20 | | | Onset and Dasi |
| | resulting in death) | a. DUE TO | DR AS A CONSE | QUENCE O | eur y | 4 | | | | | | |
| _ | | Ann | -0 1 | TILL | uno | | | | | | | i |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | " DOE TO | TOP AS A COMPE | QUENCE O | - | _ / | | | 1 | 1 | | - |
| S | cause. Enter UNDERLYING | · ando | nho Cil | 0.00 | lur.C | and | NOL | rod | cular | dit | eas | 0 |
| Ē | CAUSE (Disease or Injury that Initiated eventa | DUE TO | OR AS A CONSE | QUENCE O | n. | ,,,, | 100 | | 000-001 | COU | | 9 |
| FF | resulting in death) LAST | d. | | | | | | | | | | |
| | DADT II Other circlificant condition | | | | | | | | | | | |
| الج | PART il. Other significant condition | is contributing to | daath but not | resulting | in the und | erlying cau | ise giv | en in P | | AN AUTOPS! ORMED? | r 24b | . WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICA | | | | | | | | | 1 _ YES | 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| M | | | | | | 1/ | 1 | | | | | 1 TES 2 NO |
| z | DID TOBACCO USE CONT | RIBUTE TO CA | USE OF DEA | ATH YE | S N | O 12 U | NCE | RTAIN | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLA | CE OF DEAT | TH (Check on | lly one) | | , | | | | |
| S | 1 TYES 2 10 | 1 Inpatient 2 | ER/Outpatient 3 | □ DOA | OTHER: | ng Home 5 | Reald | dence 8 | ☐ Other (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF (Month, D | | 28b. TIM | E OF 2 | 8c. INJURY A | NT . | | 28d. DESCRIBE HOY | V INJURY O | CCURED | |
| 1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | | | | |
| | 3 Suicide S Could not be 28s. PLACE OF INJURY - at home, farm, street, fectory, office 28s. LOCATION (Street and Number or Rural Route Number, building, set, Specific | | | | | | | | | | | |
| e W 4 Homicide defermined | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | |
| COMPLET | one) 2 MEDICAL EXAMINE | | | | | | | | | | | a) and manher as stated |
| _ | 29b. SIGNATURE AND TITLE OF CENTIFIE | | | | | | - | SE NUMB | | | - | 1 |
| BE | A 1- | 7. N | 10 | | | 290. | 10 | - AUMB | 5661 | 290, DA | TE SIGNED | 59/0/ |
| 2 | 20 NAME AND ADDRESSION PURCON WA | O COMPLETED CALL | V | | | | 1 | N | 001 | | 10 | 1170 |

ETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRATE SIGNATURE

OHMH-18 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / DEPA CERTI | | | | | MENTAI | HYGIEN | _ | 30 | 0010 |
|--|--|--------------------|--|-------------------------------|-------------|-------------|--------------|-------------------------|--------------------------------|--|---------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) CARMEN TROXE | LL F | OX HARNEI | 3 | | | | 2. DATE MONTH JAN | | | YEAR 996 | 3. TIME OF DEATH 9:31 a M |
| | 4. SOCIAL SECURITY NUMBER 215-18-1131 | 5. SEX 1 M 2 XF | 6. AGE (In yrs. last birthde) 76 YAS. | MONTHS | DAYS | IF UNDE | MIN. | (Month | Dey, Year) | BIRTHPLACE (State or Foreign Country) MARYLAND | | |
| TOR | 96. FACILITY NAME (If not institution, give start FREDERICK MEMORIAL RESIDENCE OF DECEDENT | | ral . | | Y, TOWN O | | ON OF DE | | | 9c. COU | INTY OF DE EDERI | ATH |
| DIRECTOR | 100. STATE 106. COUNTY MARYLAND FREDI | ERICK | | TY, TOWN | | TION | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 126 WILLOWDALE DI | RIVE AP | г. # 14 | | 101 | . ZIP COD | 21702 | 2 | | 10g. CIT | US | HAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? | NT EVER IN U.S. ARMED VES 2XXNO MAR OR DATES | 13. | If yes, sp | ecity Cubi | | in, Puerto f | ? (Specify Yea licen, etc.) | e or No— | Specify | - American Indian, White, elc. |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | | life Do NOT | of work done use retired.) | during mo | st of worki | | | KIND OF BU | | | L SYSTEM |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) LESLIE 19e. INFORMANT'S NAME (Type/Print) | FOX | | | | BI | RDIE | | Aiddle, Maiden | TI | ROXELI | |
| 2 | BEVERLY HARNER BO | ORKE | 1974 | 15 BL | ACK | OLIV | | NE E | 7 | ATON | , FLO | RIDA 33498 |
| | 1 Burlet 2X Cremation 3 Rame 4 Donation 5 Other (Specify) | | 206. PLACE AND DAT COMPLETY, COMPLETORY OF SMITHSBUF | other place RG CR | EMAT | ORY | SS OF FA | 2/1 | . SM | ITHS | - | MARYLAND |
| | . P. Keve | in Jud | 4 | | SKIL | es fi | UNERA | AL HC | ME T | ANEY | rown, | DRE STREET MD 21787 |
| | 23. PART I. Enter the diseases, or canock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ca | use on aech line. | | | | | | | | | Approximata Interval Batween Onset and Daath |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted avents resulting in death) LAST | DUE TO | O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE | OF): | o Lu | گو | , | | | | | 1044 |
| 0 | PART II. Other algnificent condition HYPER TENSIO | | | | | | | Part i. | 24a. WAS AMPERFO | RMED? | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICA | DID TOBACCO USE CONTI | HOSPITAL: | 26. PLACE OF DE ER/Outpatient 3 (X/DOA) | OTHE | k only one) | | | 8 🗆 Othe | r (Specify) | | | |
| 2 & Accident 17/96 1 M 1 VES 2 V NO 17 V | | | | | | | oute Number, | | | | | |
| COMPLETED | | | of my knowledge, death occurs and a second occ | | | | e, and due | to the cau | | nner as st | nted, | |
| TO BE CC | 29b. SIGNATURE AND TITLE OF CERTIFIES AN AVERAGE 30. NAME AND ADDRESS OF PERSON WH | Donel | son m | | D | 29c, LIC | 219 | MBER | 1/3 | | TE SIGNED | (Month, Day, Year) 31, 1996 |

, M.D. 915 TOLLHOUSE
32. REGISTRAR'S SIGNATURE
Film Student Research #203 FREDERICK, MARYLAND 21701

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DONELSON,

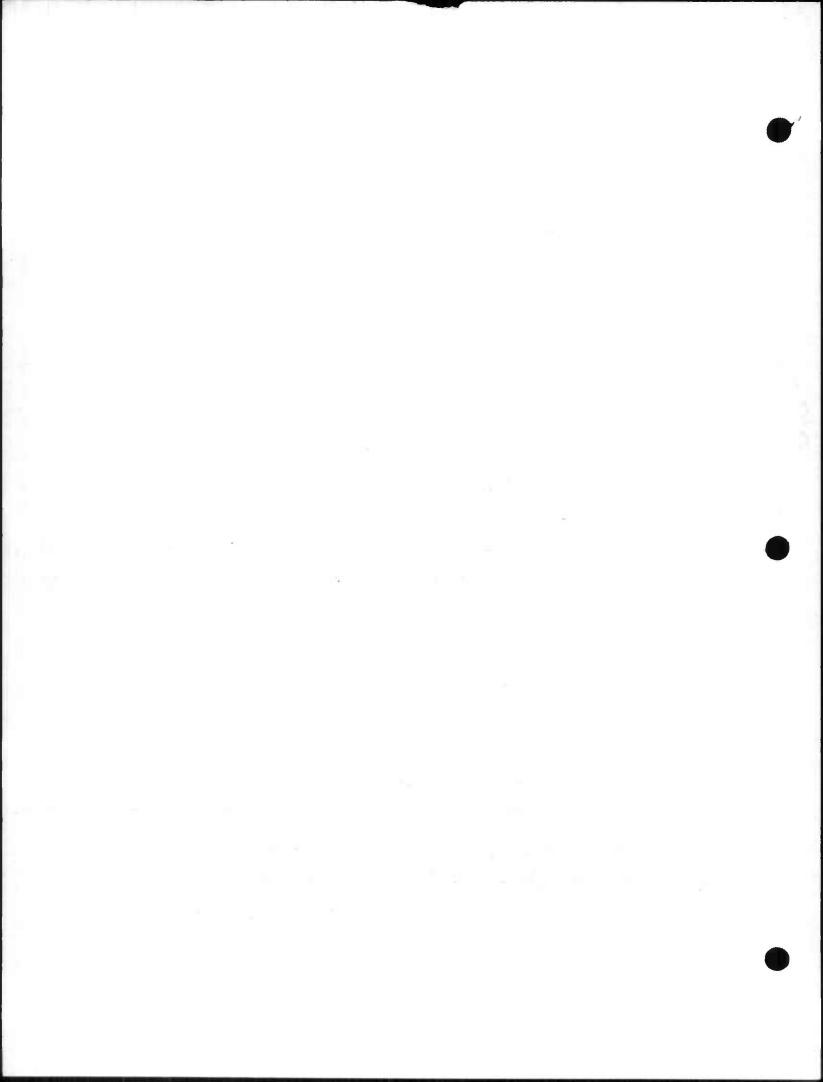
2 1996

ANDREW

31. DATE FILED (Month, Day, Year)

0.

DHMH-16 Rev 1/89



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BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

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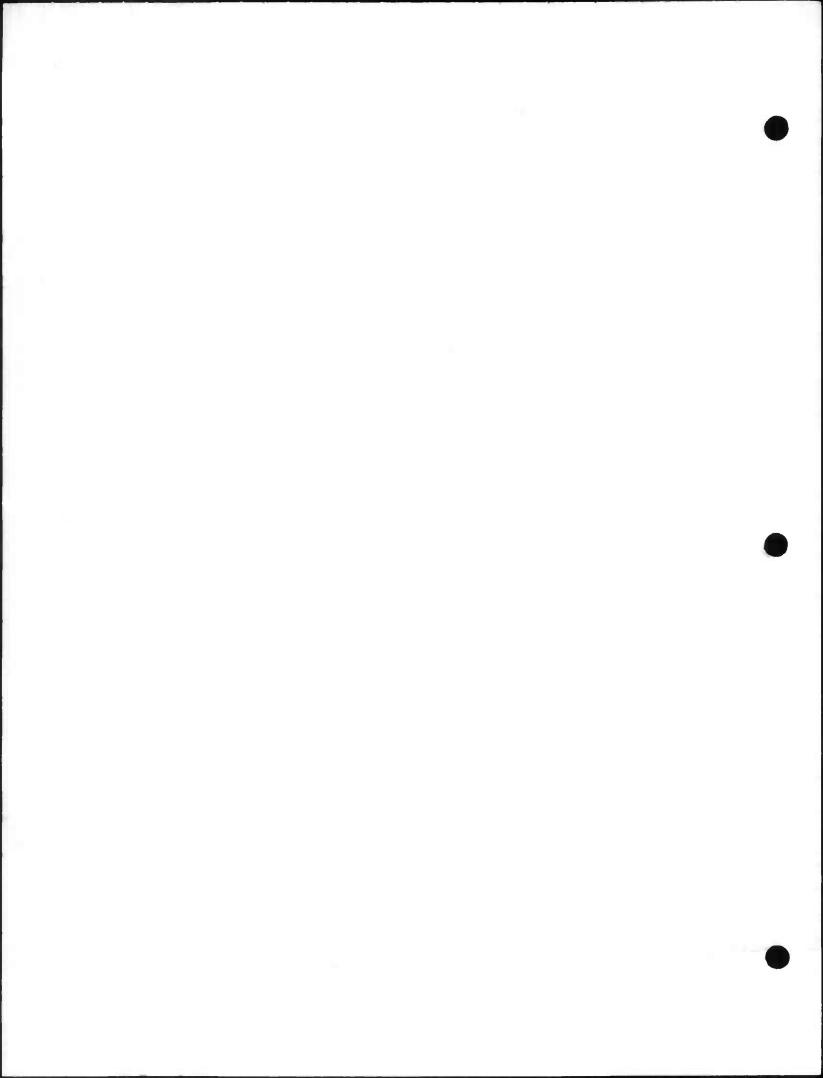
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executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. certificate be the death that A. OR ATTENDING PHYSICIAN: The After this certificate the death with the State

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Earl Richard January 27 Hart 1996 6:40 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 YM 2 F HOURS 284-14-2147 75 YRS. Sept. 5, 1920 Ohio filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Collingswood Nursing Center Rockville Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 299 Hurley Avenue 20850 United States WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
 If yes. specify Cuben, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Pt. 1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR OATES В 3 Wildowed 4 Divorced Specify: White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INQUISTRY (Specify only high dary (0-12) College (1-4 or 5+) 12 Wordsmith Defense Contractor notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Earl Edward Hart Kathryn Quinlan BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Timothy R. 17920 Ashton Club Way. Hart Ashton, MD 20861 pe 20e. METHOD OF DISPOSITION
1 □ Buriel X M Cremetton 3 □ Removal from State
4 □ Donation 6 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Chesapeake Crematory 1-29 Beltsville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P. A. Delo 933 Gist Avenue, Silver Spring, MD 20910 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final has been signed by the attending physician and completely filler. Dept. of Health and Mental Hyglene prior to burial, cremation, 1.23 shows any Injury, or other traumatic event, the I **Onset and Death** disease or condition_ aryngea year resulting in death) DUE O (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 X NO 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? or item 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Input on 2 | ER/Output on 3 | DOA OTHER: 1 YES 2 X NO me 5 - Residence 6 - Other (Specify) 28e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF GEATH marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO 1XX Natural 5 Pending investigation 1 YES 2 NO B 2 Accident
3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) DIRECTOR: Aft hours after de-item 28 is n 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 8 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: It Item 2: 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(e) and menner as stated. estigation, in my opinion, death occured at the time, data and place, and due to the cause(s) end menner as stated. 295. SIGNATURE MONTELS OF CENTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) January 29, 1996 2 30. NAME AND ADDRESS OF PERSON Walter E. Goozh. Μ. D. 2309 Shorefield Road, Wheaton, MD 20902 32. REGISTRAR'S SIGNATURE Jalin Davidson Rawfall JAN 3 n 1996

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



State of Maryland / Department of Health and Mental Hygiene

| | | | | | | | | Cer | tificate of | Death | | | Reg. No |). | | | |
|------------|--|----------------|---|----------------------------------|--|-------------|-----------------|-----------|--------------------------------------|----------------------------|------------|-------------------------------|------------|-----------|-------------|------------------------------|-----------|
| | 100 | | 1. Decedent's Name | (First, Middle, | Last) | | | | | | | 2. Dete of De Month | eth Da | | Vana | 3. Time o | f Death |
| | Physici /Medi | | KUN | SU I | HAN | | | | | | | Januar | | , 19 | 96 | 6:15 | 5 P.M. |
| | Examir | | 4e. Facility Neme (If | not institution, | give street and n | umber) | | | | 4b. City, To | own, or Lo | ocation of Deat | | _ | of Deeth | | |
| 7 | | | 3620 Maj | estic 1 | Lane | | | | | Bow | Le | | | Pri | nce (| George | 28 |
| Т | Funeral | | 5. Social Security Nu | mber (| S. Sex | 7. Age (| (In yrs. last b | irthday) | if Under 1 Yea | | 24 Hrs. | 8. Dete of Bid (Month, De | th | | | olece (State o | |
| 8 | Director | | 103-70-6 | 051 | 1 M 2□ F | 6.1 | 1 | Yrs. | Months Days | Hours | Min. | March | 19.1 | 934 | Kor | | |
| | P. | | Usual Residence of | | | | | | | | | | | | | | |
| | how | | 10e. State | 10b. County | | 1 | Oc. City, Tov | vn or Lo | cation | | | | | | 1 | 0d. Inside C | |
| | P Ma | cto | MD | Princ | ce Georg | es | В | owie | | | | | | | | X □ Yes | 2 No |
| | ₽ % | Director | 10e. Street and Num | ber | | | | | 10f. Zip Code | | | | 10g. Ch | izen of V | What Cour | itry? | |
| | 23a | | 3620 Maj | estic 1 | Lane | | | | 2071 | 5 | | | Un | ited | Sta | tes | |
| | 72 hours effer deeth with the Maryland "netural", or flems 23a or 28a-f show odjest Examiner must be notified at | Funeral | 11. Marital Status | | 12. Was Dec | | er in U,S. | 13. V | Vas Decedent of Yes, specify Cu | Hispanic Or ban, Mexice | igin? (Sp | ecify Yes or No | >- | | e - Americ | | |
| 20 | effe or H | | 1 Never Marrie | | d 1 ☐ Yes If Yes, G | 2 No | | | ☐ Yes XXX No | | | , | | | | | |
| 21215-0020 | iral. | d by | 3 Widowed 4 | Divorced | Yeer or | | | | NA. | | | | | эрвспу | Kor | ean | |
| 2 | hin 72 ho e. en "netu | Completed | (Specif | 15. Decedent's y only highest | Education grade completed |) | 16e | (Give I | ent's Usuei Occu kind of work don | e during mo: | st of work | ing | 16b. K | ind of Bu | usiness/Ind | dustry | |
| 121 | 2 . 9 | du | Eiementary/Secon | dery (0-12) | Coliege | (1-4or 5+) | | | OO NOT use retir | ed) | | | Mo | ~1d | c c | Inc. | |
| 2 | 002 | | 47 Fall of Name of | | +4 | | | Sup | ervisor | T | | | | | | THE. | |
| JE S | D S O O | Be | 17. Fether's Name (F Insuk Ha | | ast) | | | | | | | e (First, Middle | , Maider | Sumam | 10) | | |
| 3 | should be and Mental amarked of umatic eve | 7 | | | | | | | | | | n Rho | | | | | |
| Maryland | | | 19a. Informent's Nar | | p (Type, Print) | | | | g Address (Stree | | | | | | | Code) | |
| e è | Peges 1 and 3 ment of Health ant: If item 27 i ury or other tri | | Uni Ha | | | T | | | Majest | ic Lai | ie, E | | | 2071 | | | |
| 0 | ges toth | | 20e. Method of Dispo 1 ☑ Burial 2 □ | | Removel from | State | cemete | ry, crem | natory or other pl | ., | 1 | Dete | | | City or To | wn, State | |
| Ë | men men tant: jury | | 4 Donetlon | | | | Calv | ary | Hill Ce | metery | 7 12 | 2/2/96 | Da | llas | , TX | | |
| Baltimore, | permit. Pages Department of Important: If it any Injury or once. | | 21. Signature of Fun | eral Service L | censee | 11 | 200 | | Name end Add | | | and Hom | | | | | |
| ш | 707 e d | | Tani | M | nt- | 140 | llan | 11 | 800 New | Hamps | shire | Ave S | ilve | r Sp | ring | MD 20 |)904 |
| | | | Shock, or heart | diseese, or co | omplications that | ceused th | e death. Do | not ente | er the mode of dy | ing, such as | cerdiac | or respiratory a | rrest, | | | Approximatintervai Bet | te |
| 1 | Physician | | | | | | | | | | | | | | | Onset and | Death |
| À | /Medical | | Immediete Cause (F disease or condition | | 5 | Sal | hage | 06 | 2 00 | rnco | 7 | | | | | | |
| | Examiner | | resulting in death) | | a. | Du | ue to (or es a | conseq | uence of): | 11/10 | | | | | | | |
| | D # | iner | | | h | ('Ve) | 7_ (| an | uence of): | mes | 615 | tatec | _ | | | | |
| | certificate be executed ding physicien and ise as the buriel-trensit | Examiner | Sequentially list conditions, leading to imp | ditions, | D | Du | ue to (or as e | conseq | uence of): | 1100 | | | | | | | |
| , 0 | e exe ien a uriel- | | ceuse. Enter Underl Cause (Diseese or in | nediate ying | | | | | | | | | | | 1 | | |
| 68760, | ate b hysic the b | edicai | that initiated events resulting in death) La | | C | Du | e to (or as e | consequ | uence of): | | | | | | - 1 | | |
| 9 × | death certifica ettending pt d for use es ti | /Mec | | | | | | | | | | | | | 1 | | |
| Bo | | | | | 0. | | | | | | | | | | 1 | | |
| | 0 0 % | Physician | Part II. Othar algnific | ant condition | contributing to | death but r | not resulting | in the un | derlying ceuse g | iven in Part | ſ. | 23b. Dld | tobacco | use co | ntribute to | the ceuee | of death? |
| P.0 | requires that the de sen signed by the e hould be deteched t | Ph | | | | | | | | | | 10 | Yae 2 | No XNo | 3 Pro | bably 4 |) Unknown |
| Ś | es the | by | | | | | | | | | | | | | | | |
| ecords, | v require been si should b | ted | | | | | | | | | | 24a. Was | an auto | psy | av | ere autopsy allabie prior | to |
| S | 2 S S | pie | | | | | | | | | | | | | | mpletion of deeth? | ceuse |
| α | 0 - 5 | Completed | | | | | | | | | | 10 | Yes 2 | □ No | 10 | ☐Yes 2□ |] No |
| Vital | certificate rector, pag | Be C | 25. Was cese referre | d to medical | | | | | | 26. Plec | e of Deet | h (Check only | one) | | | | |
| ₹ | 5 00 | To | examiner? | lo | Hospital: | inpatient | 2□ER/O | utpatien | 3 DOA | ther: 4 🗆 N | ursing Ho | me 5 KRes | dence | 8 Oth | er (Specif | (V) | |
| J Of | | | 27. Manner of Death | | 28a. Date | of injury | | Time of | 28c. Ini | | | 28d. Describe | how inju | ry occur | red | | |
| ō | Attending or death. actor: Afte by the fune | atic | 1 Naturel 2 Accident | 5 Pending investigat | | nan, bay r | oui, | mijory | | Yes 2 | No | | | | | | |
| Division | or Attendent efter deat Director: | Certification: | 3 ☐ Suicide 4 ☐ Homlcide | 6 Could no determin | ed 288. Plac | e of Injury | - At home, for | arm, stre | et, fectory, office | • | | 28f. Location (City or To | | | er or Run | I Route Num | nber, |
| ō | al or A s efter of Direct | Cer | 4 E Homodo | | Dunc | any, etc. (| Specify/ | | | | | Only or 10 | wii, Olali | "/ | | | |
| | Hospita 24 hours Funeral etely fille | | 29a. Certifier (Check only | Certifying | Phyalcian: To the | e best of n | ny knowledg | e, death | occurred at the | time, date a | nd piece, | end due to the | ceuse(s |) end ma | nner as s | teted. | |
| | To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by | edical | one) | Medical Ex | caminer: On the bear on the bear on the bear of the be | nner state | d. | na/or inv | estigation, in my | opinion, de | ath occur | red et the time, | gate en | J place, | and due to | the cause(| S) |
| | To the comple | Σ | 29b. Signature and ti | tle of certifier | | | | | 29c. Licer | se number | | | 29d. Da | te signe | d (Month, | Day, Year) | |
| | | | 7 | of Son | H. A. | n | 20 | | 7 | 1490 | 5 | | Jan | uary | 30, | 1996 | |
| | | | 30. Name and address | ss of person wh | no completed cau | ise of deet | th (Item 23a) | (Type, I | | , -, -, - | 7 | | | | | | |
| | | | | | H. Yoon | | | | | , #11: | L, Co | ollege | Park | , MI | 20 | 740 | |
| | Sta | te | 31. Dete filed (Month | , Day, Year) | 32.1 | Registrar's | Signeture | | | | | | _ | | | | |
| | Registr | | ſ | FR nt | 1996 | Whi d | Mudler | Red | all | | | | | | | | |
| DH | MH 16 Rav 6/9 | 5 | | ~ | 0 | | | | V | | | | | | | | |

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | MENT OF I | | MENTAL HYGIENE REG. NO. | | | | |
|--|--|---|-------------------------------------|--|---|------------------------------|------------------|---|--|--|
| \neg | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | William Alfred | Hohmes | | | | MONTH 2 DAY | 4 9 | 7 1350 M | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (// | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign | | |
| | 216-01-5545 9e. FACILITY NAME (If not institution, give str | t 🔀 M 2 🗆 F | 81 YRS. | MONTHS DAYS | | July 17,19 | 14 M | Country) laryland | | |
| OR | Holy Cross Hospita | | | | or Location of DE | ATH | Montg | | | |
| ᇈ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 44.000 | TOWN OR LOCA | | | | | | |
| DIRECTOR | 100.000111 | roll | | cesville | .11. | | | 10d. INSIDE CITY LIMITS? | | |
| | 100. STREET AND NUMBER | 1011 | _ Jyl | | f. ZIP CODE | | 10- CITIZEN | t YES 2 NO | | |
| FUNERAL | Har Heart Street | | | " | | , | iog. Citizen | | | |
| N. | 2306 Lake Circle 1 | UTIVE 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DE | 2178 | 4 IC ORIGIN? (Specify Yes | or No. 14 | RACE — American Indian. | | |
| BY FL | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 X YES | 2 NO TES | II yes, s | ecity Cuban, Mexican 2 📉 NO Specify: | n, Puerto Rican, atc.) | | Black, White, atc. Specify: White | | |
| | 15. DECEDENT'S EDUC | 1942-1945 | 16e. DECEDENT'S I | ISHAL OCCUPATI | ON | 16b. KIND OF BUSI | INESS/INDUST | | | |
| COMPLETED | (Specify only highest grade of Elementary/Secondary (0-12) | Completed) College (1-4 or 5+) | (Give kind of w life. Do NOT use | ork done during m | ost of working | 160. KIND OF BUSI | NESS/INDUS I | MY . | | |
| 7 | 12 | College (14 br 5+) | Mail F | Room Sur | ervisor | United | States | Government | | |
| S S | 17. FATHER'S NAME (First, Middle, Lest) | | | • | 18. MOTHER'S NAM | WE (First, Middle, Melden S | Surname) | | | |
| BEC | Albert Hohmes | | | | Barbara | Bergman | | | | |
| TO B | 19s. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | | loute Number, City or Town | , State, Zip Coc | do) | | |
| F | Alice S. Hohmes | | 2306 I | Lake Ci | cle Driv | e, Sykesvi | lle, M | D 21784 | | |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remo | val from State ceme | PLACE AND DATE O | F DISPOSITION (Name place) | ame of | DATE 20c. LOC | ATION — City | or Town, State | | |
| | 4 ☐ Donation 5 ☐ Other (Specify) | tuess / | rklawn N | lemoria | Park 1/2 | 27/96 Roc | <u>kville</u> | , MD | | |
| | -1//// | 1411111 | | | | llins Fune: | ral Ho | me. Inc. | | |
| 1211 | Mach | Vellelles | | 500 t | niversit | y Blvd.W. | Sil.Sp | r.MD 20901 | | |
| | 23. PART I. Énter the diseeses, or c shock, or heart failure. I | omplications that caused list only one cause on at | | ot enter the me | ode of dying, such | as cardiac or respir | etory arrest. | Approximate interval Between | | |
| | | | | | | | | | | |
| | resulting in death) | 0. 0.00.40.40 | muy | a | -will | our O | | somebil | | |
| | immediate Cause (Final disease or condition resulting in death) Onest and Death Onest and Death Onest and Death Assumeba | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, DUE TO (OR AS A CONSCIUENCE OF): | | | | | | | | | |
| SAT | cause. Enter UNDERLYING | if sny, leading to immediate cause. Enter UNDERLYING | | | | | | | | |
| Ĭ. | CAUSE (Disease or injury that initiated events | DUE TO (DR AS A | CONSEQUENCE OF |): | | | | | | |
| HH | resulting in deeth) LAST | 1. | | | | | | | | |
| | PART ii. Other significant condition | s contributing to deeth by | it not regulting i | n the underlyin | a ceuse alven in l | Part i. 24a, WAS AN | ALITOPSY | 24b. WERE AUTOPSY FINDINGS | | |
| CAL | | nunn | | | g code given in | PERFORI | MED? | AWAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| PHYSICIAN: MEDIC | Chrona Ol | Muster A | Man | - 9 | non | 1 YES 2 | SNO | OF DEATH? | | |
| Σ. | DID TOBACCO USE CONTE | RIBUTE TO CAUSE O | F DEATH YE | S IP NO I | UNCERTAIN | | l l | 1 TES 2 NO | | |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | 8. PLACE OF DEAT | | | | | | | |
| Sic | EXAMINER? | HOSPITAL: | etlent 3 🗆 DOA | OTHER: | ne 5 🗆 Residence | 8 Other (Specify) | | | | |
| 첫 | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. IN | JURY AT ORK? | 28d. DESCRIBE HOW IN | JURY OCCUR | EO | | |
| ВУ | t Natural 5 Pending 2 Accident Investigation | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | YES 2 NO | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | ie . | 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stetle) | | | | | | |
| COMPLETED | 29e. CERTIFIER | | | | | | | | | |
| MPI | (Check only | CIAN: To the best of my knowl | | | | | | | | |
| 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and man | | | | | | | | | | |
| BE | 29h. MONATURE AND TITLE OF CERTIFIES | 21 6 0 | .51 | | 29c. LICENSE NUM | BER | 29d. DATE SI | GNED (Month, Day, Year) | | |
| 6 | 30. NAME AND ADDRESS OF PERSON WHO | a complete 10 | TH OTES AT A | Del-et | 100117 | 0 | - | 165-76 | | |
| | 13975 Comm | 1 | LUP, | SILVE | n 50 | PRING | 1. | D 2090: | | |
| | JAN 30 199 | 6 32. REGISTRAR'S SIGN | ATURE Randall | | | | | | | |
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IMPORTANT: If item 28 is marked, COMPLETED

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96 03741 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH January 27, 1996 MILDRED 04:10 A D. **IMES** 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS HOURS 1 M 2 F 217-28-9659 May 24, 62 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memorial Hospital & Medical Center Cumberland Allegany RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Allegany MD Oldtown 1 YES 2X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Route 2 Box 74A USA 21555 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Bleck, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Married
3 Widowed 4 Divorced BY Specify: white COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Hayes Ray Gordon Margaret Ann (Powell) BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 21555 John R. Imes Route 2 Box 74A; Oldtown, MD 24s. METHOD OF DISPOSITION
143 Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE LaVale, MD Restlawn Memorial Gardens 1/31 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home Cumberland, MD 21502 23. PART I. Exter the diseases, or complications that caused the desphock, or heart failure. List only one cause on each line. ih. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximata Interval Batween **IMMEDIATE CAUSE (Final** Onset and Death disease or condition ADENOSQUAMOUS CARCINOMA LUNG 1 YEAR resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (DR AS A CONSEDUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. BY PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

| 25. WAS CASE REFERRED TO MEDICAL | 26. PLAC | CE OF DEATH (Check | only one) | |
|---|---|-----------------------------|----------------------------------|---|
| EXAMINER? 1 YES 2 NO | HOSPITAL: Inpatient 2 ER/Outpatient 3 | OTHE | R: rsing Home 5 - Rasidenca | 6 Other (Specify) |
| 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d, DESCRIBE HOW INJURY OCCURED |
| 3 Suicida 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At he building, atc. (Specify) | ome, tarm, atreet, fac | tory, office | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| onel | | | | to the cause(a) and menner ee stated. If time, data and placa, and due to the cause(a) and menner as stated. |

29c. LICENSE NUMBER

| W | Man | turn | mp | | D25406 |
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| 20 NAME A | ND ADDRESS OF BEREO | N WHO COMPLETED ON | OF OF DEATH STEEL OF | CT District | |

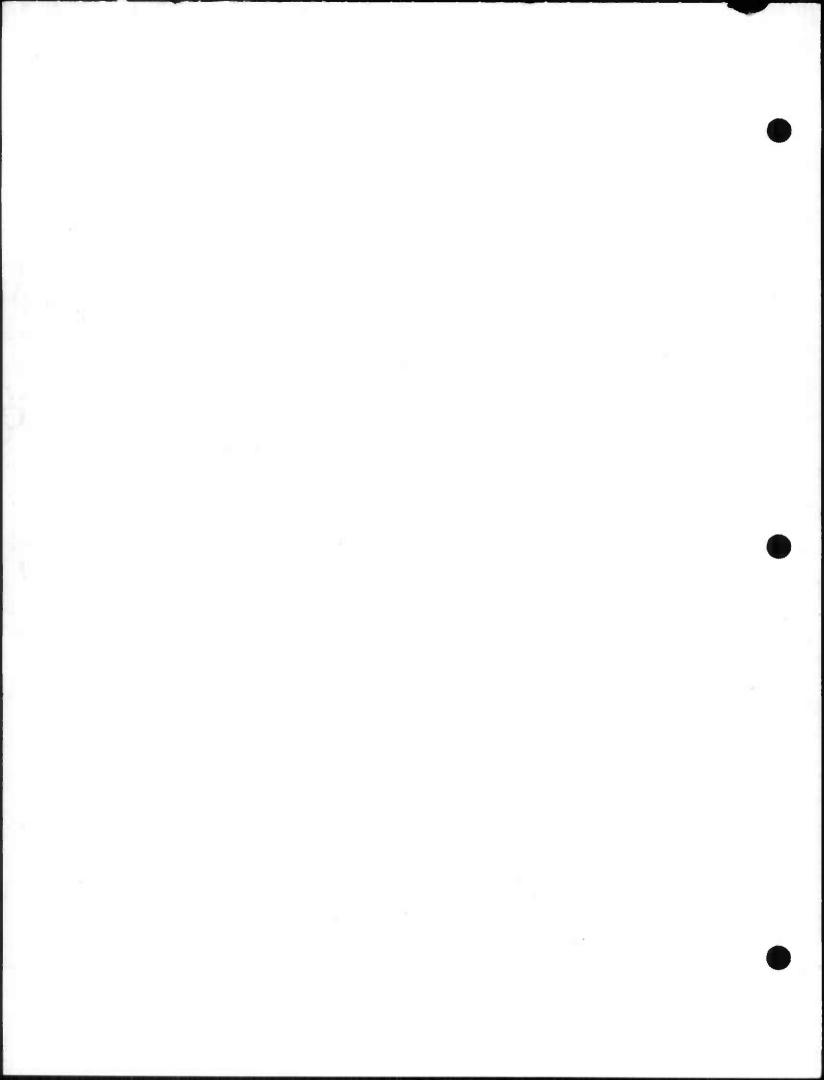
Dr. W. Lamm 47 Virginia Avenue Cumberland, Md. 21502

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE JAN 3 1 1996

296 SIGNATURE AND TITLE OF CERTIFIER

29d. DATE SIGNED (Month, Day, Year)

▶ January **29** 1996



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| STATE OF MARYLAND | DEPARTMENT | OF HEALTH | AND | MENTAL | HYGIENE | |
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| C | ERTIFICATE | OF DEAT | H | | REG. NO. | |

| 1 | | | | CATE OF DEATH | REG. NO |). | | | |
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| | DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH | DAY YEAR | 3. TIME OF DEATH | | |
| | IVA ANGELI | | RELAND | | JANUARY | 24 1996 | 6 02:15 AM | | |
| | 296-03-2094 | 1 🗆 M 2 😾 F | 87 YRS. | FUNDER 1 YEAR IF UNDER 24 HRS ONTHS DAYS HOURS MIN. | | Col | TTHPLACE (State or Foreign untry) | | |
| 5 | B. FACILITY NAME (If not institution, give at | | | b. CITY, TOWN OR LOCATION OF | DEATH | 9c. COUNTY OF | F DEATH | | |
| ~ O | SACRED HEART HOS | PITAL | | CUMBERLAND | | ALLEG | ANY | | |
| DE 100 | De. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? | | |
| i i | WV Miner | al | Rid | geley | | | 1 TYES 2 NO | | |
| 020 physician. bunal-transit permit. Pages FUNERAL DIREC | | | | 10f. ZIP CODE | | | F WHAT COUNTRY? | | |
| UNE In-trans | Route 2 Box 371 | 12. WAS DECEDENT EVER II | N U.S. ARMED | 26753 | ANIC ORIGIN? (Specify Y | USA on or No — 14. R/ | ACE — American Indian, | | |
| g a g 3 | Never Merried 2 ☐ Merried X. Widowed 4 ☐ Divorced | FORCES? 1 YES | 2 XNO ATES | If yea, specify Cuban, Max 1 TYES 2 X NO Spe | | 10.00 | white | | |
| the hospital or attend detached for use as once. | ts. DECEDENT'S EDUC (Specify only highest grade | ATION pompleted) | 16a. DECEDENT'S U | SUAL OCCUPATION k done during most of working | 16b. KIND OF BI | USINESS/INDUSTRY | | | |
| for tall or | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | | | | | |
| detached det | 1 2 7. FATHER'S NAME (First, Middle, Last) | | Homemak | | Own He | | | | |
| के वै व | George Creamer | | | | | n Surname) | | | |
| o retained by the hospits 5 should be detached notified at once. TO BE COMPI | Da. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DESS Street and Number or Rur | e (Park) Il Route Number, City or To | wn, State, Zip Code) | | | |
| | Ruby Cox | | Route | 2 Box 371; Rid | geley, WV | 26753 | | | |
| ed may be corrected and see an | 0a. METHOD OF DISPOSITION ☐ Burlei 2 X Cremation 3 ☐ Remo | val from State cen | PLACE AND DATE OF | DISPOSITION (Name of | | OCATION — City or | Town, State | | |
| 0 2 - | Donation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE LIC | ENDEE | Cumberlanc | Crematory 22. NAME AND ADDRESS OF | | umberlar | nd, MD | | |
| funeral funeral | Da as a so | Z Man | noll. | Scarpelli Fu | neral Home | | | | |
| | 23. PART I. Enter the diseases, or c | omplications that cause | d he deeth. Oo no | Cumberland, | MD 21502 | piratory arrest. | Approximata | | |
| 5 91 | shock, or heart fellure. I | iet only one ceuse on e | ech Ilne. | | | | interval Between | | |
| pletely cremati | disease or condition esuiting in desth) | Métasto | CONSEQUENCE OF | Duarian C | arcinor | na | 2 ma | | |
| sician and corrected sician and corrected prior to burial, traumatic er. | Sequentially list conditions, | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| physician ne prior to per traun | ceuse. Enter UNDERLYING | | | | | | | | |
| Hygie RTT | het initiated events resulting in death) LAST | DUE TO (OR AS A | A CONSEQUENCE OF): | | | | | | |
| 0 0 0 | PART II. Other significant condition | e contributing to death b | out not resulting in | the underlying cause given | in Part I 24s, WAS A | IN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | |
| = Z = 4 | Malnutrit | | • | , | | ORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| Signal Read | | | | | | . K. | OF DEATH? 1 □ YES 2 X NO | | |
| 3 2 5 4 7 | DID TOBACCO USE CONTE | RIBUTE TO CAUSE C | | | AIN 🗆 | | | | |
| 는 음음 등 진 | 5. WAS CASE REFERRED TO MEDICAL EXAMINER? | HQSPITAL: | 28. PLACE OF DEATH | (Check only one) OTHER: | | | | | |
| HYSICIAN: The nis certificate with the State (ed., or Item PHYSICI | 1 TYES ZY NO | 1 Inpatient 2 ER/Out | patient 3 DOA | □ Nursing Home 5 □ Resident | 1 | | | | |
| Z = 2 E _ H | 7. MANNER OF DEATH Netural 5 Pending Accident Investigation | 26s. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | OF 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURED | | | |
| OR: A OR: A B Is B Is ED | 3 Suicide 6 Could not be determined | 26s. PLACE OF INJURY building, atc. (Spe | (— At homa, farm, at cify) | eet, factory, office | 281. LOCATION (Stree City or Yown, Stat | t and Number or Rule) | ral Route Number, | | |
| A 40 F G | onel | | | at the time, data and place, and o | | | | | |
| HOSPITAL within 72 TANT: It COME | | A | n and/or investigation | In my opinion, death occured at | | | | | |
| N POR | taul J | wengoo | Lmo | Da3 | 774 | 12 | UARY 24 1991 | | |
| 3 | THE PILED MOVIES, OF PERSON WHITE THE PILED MOVIES, Day, Year, DAN 25 1996 | d N. S.91 | ath (ITEM 27) (Type, 1) | e, Print | | | | | |
| | 1. DATE FILED (Month, Day Year); J | 32 REGISTRAR'S, SIGN | ATUBE | | | | | | |

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| State of Maryland / Department of Health and Mental Hygien 96 | 03 | 14 | |
| Certificate of Death | | | |

| Physici /Medic Examin | al |
|-----------------------------|----|
| Funeral Director | |

| | | | Cei | rtificate of | Death | Re | g. No. | | |
|---|--|--------------------|--|--|---------------------------------|---|---|--|--|
| | Physic /Medi | | Decedent's Nema (First, Middle, Last) RODNEY DAVID | JONES | | 2. Dete of Deeth Month JAN | | . 9 9 ′6 | 3. Time of Death 10:00 AN |
| | Exami | | 4a. Facility Name (If not Institution, giva street end number) EASTON MEMORIAL HOSTITAL | | 4b. City, Town, or Lo EASTON | | 4c. County TALE | | |
| | Funeral Director | | 5. Social Security Number 8. Sex 1 M 2 F 7. Aga (In yrs. last birthdey) Usuel Residence of Decedent | If Under 1 Yeer Months Days | | 8. Date of Birth (Month, Day, | | | lace (State or Foreign try) Ry I a Nd |
| | he Maryland 8a-f show ptried st | Director | 10a. Stela 10b. County 10c. City, Town or Lo Maryland Dorchester Camb | | | | | | 0d. fnside City Limita 1 ☐ Yes 2 ☑ No |
| | s 1 and 2 should be filed within 72 hours after death with the Manyland I Health and Mental hygiene. Then 27 is marked other than "naturel", or heme 23s or 28s-f show other treumstic event, the Medical Example must be notified at | Funeral Dire | 4858 - DRawbridge Road 11. Marltal Status 12. Was Decedant Ever in U.S. 13. Armed Forces? | 21613 | | | | What Count 5 e - Amarica ck, Whita, e | an Indian, |
| -0020 | hours aft turel, or | by | 3 ☐ Widowed 4 ☐ Divorced If Yes, Giva Year or Detes: | 1 ☐ Yea 2 🗐 No | | | Specify 16b. Kind of Bi | D10 | ck |
| 21215-0020 | d within 72 giene. rr than "na r the Modic | Completed | (Specify only highest grada completed) Elementery/Secondery (0-12) College (1-4or 5+) | kind of work done | during most of work ed) | ing | 0. | | eutical |
| Maryland | ould be file Mental Hy arked othe | To Be C | Paul Jones | | 18. Mother's Name | a E | Nelden Sumen | ne) S | |
| Ore, Mises 1 and 2 of Health a | of Health a litem 27 is rother tree | | MR. I MRS. Paul Jones 485 20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) 20b. Pleas of Dispocamatary, cran | S-DRAW sition (Name of metory or other ple CEME 2. Nama and Addr | HERY ess of Facility | Date C | abridge Poc. Location - | e Mak Sity or Too | yland 21613 m, state , Maryland |
| | Physician /Medical Examiner | , | C. San Part Letter the disease, or complications that caused the deeth. Do not antended to the control of the c | 4 | | or respiretory arre | ol, I | | Approximate Interval Between Onset and Death |
| OX 68/60, t certificate be executed inding physician and use as the burial-transit | 5 5 5 | n/Medical Examiner | Cause (Diseesa or Injury that initieted events resulting In death) Last C. Dua to (or as a consequence of the consequence of | | | | | - | |
| P. | 0 0 | Physician | Pert fl. Other significant conditions contributing to death but not resulting in the u | nderlying ceuse gi | iven in Pert I. | | bacco use co | | the cause of death? |
| Records, | r requir been s should | Completed by | | | | 24a. Was ar perform | autopsy ned? | cor | ere autopay findings allable prior to applation of ceuse death? |
| = | The ate h page | Be | 25. Wea casa referred to medical examiner? Hospitei: | 0 | 26. Plece of Deet | | s 2 🗆 No | 1 2 | No 2□ No |
| NVISION OT or Attending Phys ifter death. Virector: After this in by the funeral di | aling Phys | Certification: To | 1 X/es 2 No | f 28c. Inju Wc M 1 | and Nursing Ho | ma 5 Reside 28d. Describe ho ORIVER, C. 28f. Location (Str City or Town RESTON RD | W Injury occur AR STR Craet end Numb. Steta) Avn. | red OCIC BO Der or Rural ERICAN | UILDING I Routa Number, CONNER AND |
| | To the Hospital within 24 hours a To the Funeral C | edical (| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 29a. Certifying Physician: To the best of my knowledge, death one) and menner steted. | occurred at the ti | ime date and niece | and due to the ce | usa(e) and me | onner se et | hata |
| | To th Within | M | 29b. Signeture and title of cartifier Donald & Wright MD | | .C.M.E. | | JAN. 2 | | |
| | Sta | te | 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, DONALD G WRIGHT MD 111 Person 11 | enn Str | eet, Bal | timore | , Mary | land | 1 21201 |
| | Registr | аг | JAN 3 U 1996 Jan a drivelen harda | Ц | | | | | |

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| | | | | | Cer | tificate of | Death | | Re | g. No. | | |
|--|--|----------------|---|---|------------------------|---|----------------------|-------------------------------|----------------------------------|------------------|--------------------------|--|
| | | | Decedent's Nama (First, Middla, Last) | | | | | 2. Dete of Deeth 3. Time of D | | | | |
| ı | Physic | | JAMES F | JONES | 51 | 1. | | | Month | Day | Yaar 96 | 11:30 Ar |
| | /Medi Exami | | 4e. Facility Nama (If not institution, give street | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. County | - | 11 20 11 |
| М | LAGIIII | IIGI | 6838 Wilson Road | | | | Frie | ndeh- | i n | | | 1.1 |
| - | Francis | _ | 5. Social Security Number 6. Sax | 7. Aga (In yrs. I | last hirthday) | If Undar 1 Yeer | | | _ | | Arun | |
| | Funeral Director | | 213-30-9427 XDM | OF. | 7 Yrs. | Months Days | Hours | Min. | 8. Dete of Birth (Month, Day, | Year) | Cour | place (State or Foraign |
| | | | Usual Residence of Decedant | | // | | | reb. | | 24,1928 Ma | | riand |
| | land | | 10a. Stata 10b. County | 10c. City | , Town or Lo | cation | | | | | 1 | IOd. Insida City Limits |
| | 4sh | 0 | Maryland Anne Arunde | .7 | The diam | 1-1-1 | | | | | | 1 ☐ Yas 2 ▼No |
| | the 28s | Director | 10e. Street and Number | :1 | Frien | 10f. Zip Coda | | | 4/ | Og. Citizen of V | Affron Cour | -1-2 |
| | with o | | | | | | | | | Ag. Citizen of v | WHAT COUR | ntry? |
| | s i and z should be blied within 72 hours after death with the Marylar if Health and Mental Hygiene. If Health and Mental Hygiene is the manual of the manual control than 21 a marked other than "natural", or itema 23e or 28e-f show other traumatic event, the Medical Exercise mail be notified at | Funeral | 6838 Wilson Road | | _ | 207 | | | | USA | | |
| | within 72 hours after death with the Maryland ene. then "natural", or itema 23a or 28a-f show he Modical Evanines must be notified at | n | A | es Decedent Evar In U, med Forcas? | S. 13. V | Was Decedant of Hispenic Origin? (Sprif Yes, specify Cuban, Maxican, Puarto | | | city Yas or No- Rican, atc.) | | a - Americ ck, Whita, | can Indian, atc. |
| 2 | or i | by Fu | Total III | Tas 2. No Yas, Giva | 1 | I□Yas 210 No | Specify: | | | | Blac | |
| 0200-61212 | in in | | 3\\Q\\\Widowed 4 □ Divorced \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | ear or Datas: | | 21 | | | | Openin | | |
| 'n | 72 h | Completed | 15. Decedent's Education (Specify only highast grade con | | 16a. Deced | lent's Usuel Occup | oation during mos | t of workii | 100 | 16b. Kind of Bu | usinass/in | dustry |
| 7 | ithin | | | oliega (1-4or 5+) | lifa. L | kind of work done OO NOT use retire | d) | | | | | |
| | w per th | | | | | Farmer | | | | Fa | armin | ıg |
| Maryland 2121 d 2 should be filed within th and Mental Hygiene. T is merked other than " traumetic event, the Mo | | Be | 17. Fathar's Name (First, Middla, Last) | | | | 18. Motha | r's Name | (First, Middla, M | faiden Surnam | 1a) | |
| 0 | Aent Aent rked tice | 70 | Fred M. Jones Mary 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat and Number or | | | | | | Ε. | Pete | Peters | |
| al | 2 should and Men a marked | | 19a. Informant's Name/Ralationship (Type, P | 19b. Mallin | ng Addrass (Streat | and Number | er or Rura | l Routa Number, | City or Town, | Stata, Zip | Code) | |
| | od 2 27 le | | Charlotte Coleman | | 2413 (| Gaither ! | S+ 7 | Comp 1 | o Uilla | MD 20 | 17/0 | |
| mit. Pages 1 and 2 partment of Health | s 1 and if Health item 27 other tr | | 20a. Mathod of Disposition | 20b. Pi | leca of Dispos | sition (Name of natory or other pla | JC. 1 | CIIIDI | | 20c. Location - | | own, Stete |
| 2 | | | 1 ⊠ Burial 2 □ Cramation 3 □ Ramov | | | | | | E CHI | | | |
| | tant dury | | 4 □ Donation 5 □ Other (Specify) | Unic | | Church Ce | | | 27/96 | Lothia | ın, M | aryland |
| 0 | pemit. Page Department dimportant: If any Injury or once. | | 21. Signature of Funeral Sarvice Licansee | 1 10 | 22 | . Neme end Addra | ss of Facilit | y Se | well Fur | neral H | lome | |
| | 40 F # 0 | | Blacke a. A | Servel | 14 | 451 Dares | Beac | h Rd | . Prine | ce Fred | leric | k, MD 2067 |
| F | | | 23a. Part1. Entar tha disease, or complication | s that caused the death | | | | | | | | Approximete Intarval Between |
| ¥. | Physician | | shock, or haert feitura. List only one car | sa on addi ling. | | | | | | | | Onset and Death |
| /Medical | | | Immediata Causa (Finat | RUNTIA | . / | Ann. | 7 . | 0 | 1- 1- | | į. | 7 1/1. |
| | Examiner | | disease or condition rasulting in death) a. | AVATURE Due to (or | - 01 | 110/1 | . C | 17, | NEVKY | 1917 | | ZHRS |
| | | 9 | | Dua to (or | r as a conseq | uence of): | | | | | į | |
| | nsk | Examiner | b | // /// | RTZA | 15.0n | | | | | | |
| | eath certificate be assected attending physician and for use as the burial-transit | Xai | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disasse or Injury that initiated evants | Due to (or | r as a conseq | uanca of): | | | | | į | |
| 00/00 | be a loiar buri | | cause. Entar Undarlying Cause (Disaase or Injury | | | | | | | | i | |
| 0 | phys the | Medical | resulting In death) Last | Dua to (or | es a consequ | uanca of): | | | | | | |
| Y | ling ling | Me | | | | | | | | | | |
| | ten or us | an | - 0. | | | | | | | | 1 | |
| | 0 0 0 | sic | Part II. Other significant conditions contribut | ng to death but not rasu | ilting in the un | ndarlying causa giv | ven in Part I | | 23b. Did to | occo use co | ntribute to | o the cause of death? |
| 5 | requires that the de- been signed by the a should be detached to | Physician | For. 12. | 81- | A. | 10.10 | 311 3 | | 10/10 | e 2□ No | 3 Pro | bably 4 Unknown |
| | es tha igned be del | by I | LEMOKAT | 1/2 /2/29 | 1/10 | CVK151 | 75 | | | | | |
| oi vital necords, | quire or sig | | 10,7 | CT0 1 | | , | | | 24a. Wes er | | | ere autopsy findings |
| 3 | 20 07 | Completed | | STROK | e | | | | perform | led? | CO | allabla prior to implation of cause daath? |
| | has b | m | | | | | | | | | Oi | oaatn r |
| 2 | cate ha | | | | | | | | 1 ☐ Ye | 8 2 No | 10 | Yas 2 No |
| = | Physician: The this certificate ral director, page | Be | 25. Was case refarred to medical axaminer? | | | | | of Death | (Check only ene | 1) | | |
| 5 | Physic this c | To | 1 ☐ Yas /2 ☑ No Hospit | li: 1 ☐ Inpatiant 2 ☐ I | ER/Outpatient | t 3 DOA | ner: 4□ Nu | rsing Hon | na 50 Rasida | nce 6 Oth | ar (Specif | y) |
| | ding Ph h. After th funeral | ü | 27. Manner of Death 1 O Natural 5 ☐ Panding | . Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injur | ry at | 2 | 8d. Describe ho | w Injury occurr | ber | |
| 2 | Attending or death. ector: After by the fune | atic | 2 Accident Invastigation | (| ,, | | Yas 2□ | No | | | | |
| | of attendation of the control of the | Ific | 3 Suicide 8 Could not be datarmined 28 | Placa of Injury - At hor | ma, farm, stra | et, factory, offica | | 2 | | | er or Rure | al Route Number, |
| 5 | D and D | Certification: | 1 | building, atc. (Specify, |) | | | | City or Town | , Stara) | | |
| | To the Hospital or Attano within 24 hours after deati To the Funeral Director: completaly filled in by the | | 29a. Cartifiar 1D Certifying Physician | To the best of my know | vledga, daath | occurred et tha tir | ma, data an | d placa, a | nd due to the ca | use(s) and ma | innar as s | tated. |
| | P Fu | edical | [Check only 2 Medical Examinar: C | n tha basis of axaminati nd mannar stated. | ion and/or Inv | astigation, in my o | pinion, daa | th occurre | d at tha tima, da | te and place, | and dua to | tha causa(s) |
| | d thing of | Me | 29b. Signature and title of certifier | 0/ | / | 29c. Licens | e number | | 29 | d. Dete signed | d (Month | Day, Year) |
| | - 3 F 0 | | · H. 1 | 11-1 | 11/ | | _ | -/ =- | | /- | . / | |
| | | | flavey for | Reinfel | 17 | U V | 0) | 1) | De , 17 | 11 22 | 1/9 | 6. |
| | X | | 30. Nama and address of person who complet | ed causa of death (Itam | 23a) (Type, F | Print) | | | | | | 3 / 11 |
| | 0 | | MITRICH STEIN | IFELO. | M.D. | . 5F | 190 | 1511 | 18 17 | 0 | 20 | 164. |
| | Sta | ite | 31. Data filed (Mojnth, Day, Year) | 32. Registrar's Signat | | - | | | | | | |
| | Registr | ar | 1AN 90 10 | noch die A | 1 1 | 0 110 | | | | | | |

2

3

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings. Incurs after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|
|--|

| | AMENDED #19a, 1/29 1 - STATE | /96, B.P., WORCE STATE OF MARYLAND / | | | MENTAL HYGIEN | E | 06 03745 | | | | |
|--------------------|---|--|--|---|--|---|--|--|--|--|--|
| - | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | CI | ERTIFIC | ATE OF DEATH | REG. NO | | | | | | |
| | F. | YEAR 9:00 Am | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 058-12-8525 | 5. SEX 6. AGE (In yrs. las | | UNDER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 12-22-12 | | BIRTHPLACE (State or Foreign Country) MASS. | | | | |
| _ | 9a. FACILITY NAME (If not institution, give st | treet and number) | nd number) 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | | | | |
| STOR | ATLANTIC GENER | RAL HOSPITAL | | BERLIN | | Wor | CESTER | | | | |
| DIRECTOR | MD. WORD | CESTER | BERL | WN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 24 CANAL ROAD |) | | 101. ZIP CODE 21811 | | | ZEN OF WHAT COUNTRY? | | | | |
| | 11. MARITAL STATUS t Never Married 2 Married | 12. WAS DECEDENT EVER IN U.S. AR FORCES? t YES 2 | MED | 13. WAS DECENDENT OF HISP/ If yes, specify Cuban, Maxic | ANIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, stc. | | | | | |
|) BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TES 2 NO Spec | lfy: | | Specify: WHITE | | | | |
| COMPLETED | ts. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | completed) (Gi | CEDENT'S USU ive kind of work of Do NOT use reti | AL OCCUPATION done during most of working red.) | 16b. KIND OF BUS | BINESS/IND | USTRY | | | | |
| MPL | 12 | | OMEMA | | | Ном | E | | | | |
| BE CC | 17. FATHER'S NAME (First, Middle, Leat) MICHAEL CHUDZIK ANNA ZBIKOWSKI | | | | | | | | | | |
| TO B | JAMES E. JANGS (Janis) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2877 OCEAN PINES BERLIN, MD., 21811 | | | | | | | | | | |
| | 20a_METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of complany, crematory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | | |
| | Donation 5 Other (Specify) | SUNS | ET ME | MROIAL PARK 22. NAME AND ADDRESS OF F | | ERLI | N, MD. | | | | |
| | Mus Mi | WL | | ULLRICH FU | NERAL HOM | E | BERLIN, MD. | | | | |
| | 23. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heert failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | |
| | IMMEDIATE CAUSE (Fine) | | | | | | | | | | |
| | Totaling in doubly | DUE TO OR AS A CONSEC | OUENCE OF): | / | | | 30243 | | | | |
| FICATION | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | |
| = 1 | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A CONSEC | DUENCE OF): | encin | | | 6 month | | | | |
| CERT | resulting in deeth) LAST | l | | | | | | | | | |
| | PART II. Other significent conditions | contributing to deeth but not re | esulting in th | e underlying ceuse given in | Part I. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | |
| PHYSICIAN: MEDICAL | | | | | 1 🗆 YES 2 | NO | OF DEATH? | | | | |
| AN: | DID TOBACCO USE CONTR | | | | N 🗆 | | | | | | |
| SICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 VAO 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Dey, Year) | 28b. TIME OF INJURY | 28c, INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW IF | NURY OCC | URED | | | | |
| ED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY — At hos building, etc. (Specify) | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only | CIAN: To like best of my knowledge, dec | ath occurred at | the time, date and place, and du | to the cause(a) and men | ner as atale | ad. | | | | |
| COM | 2 MEDICAL EXAMINER | R: On the besia of axamination and/or in | | | | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | K Rober | t. D | 29c. LICENSE NU | | 29d. DATE | SIGNED (Month, Day, Year) | | | | |

| 28. PLACE OF DEATH (Check only one) OSPITAL: OTHER: Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Spe | CIE TO GROOT OF DESCRIPTION | .0 [110 [] | OTTCERTAL | |
|--|--|------------------------|-------------|-------------------|
| OSPITAL: OTHER: OTHER: OTHER: OTHER: | | | | |
| The state of the s | OSFITAL: Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home | 5 Residence | 8 Other (Specify) |

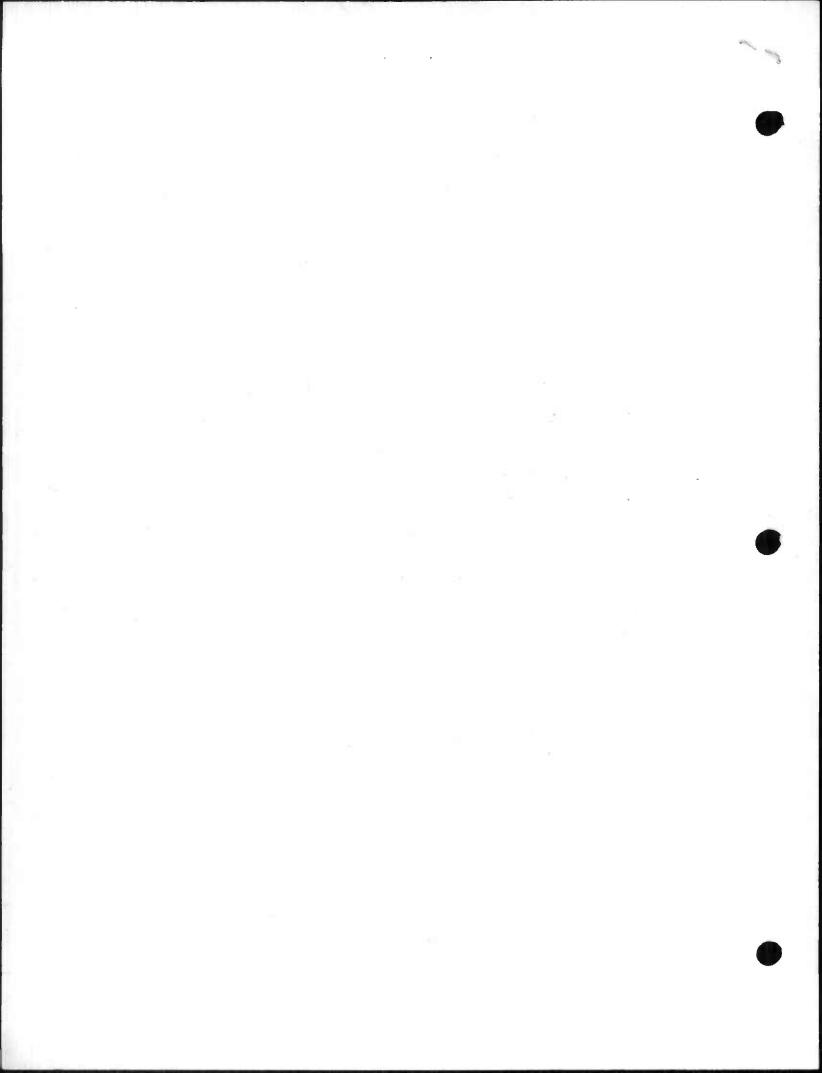
| 10. | R | ~ K | 160681 | DUPKI. |
|-----------------|-----------------|----------------|---------------------|--------|
| 30. NAME AND AD | DRESS OF PERSON | WHO, COMPLETED | CAUSE OF DEATH (ITE | |

29c. LICENSE NUMBER

29d. DATE ŞIGNED (Month, Day, Year) 9

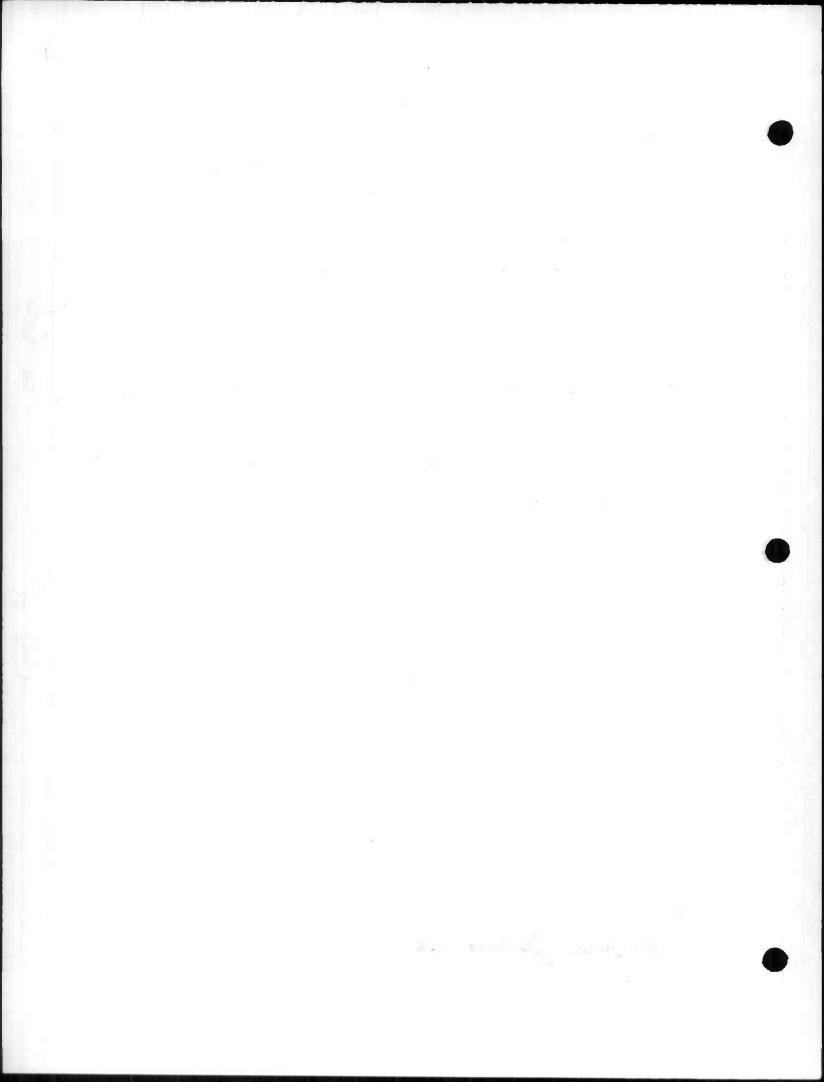
30. NAME AND ADDRESS OF PERSON WHEN THE PROPERTY OF THE PROPER

32. REGISTRAR'S SIGNATURE



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

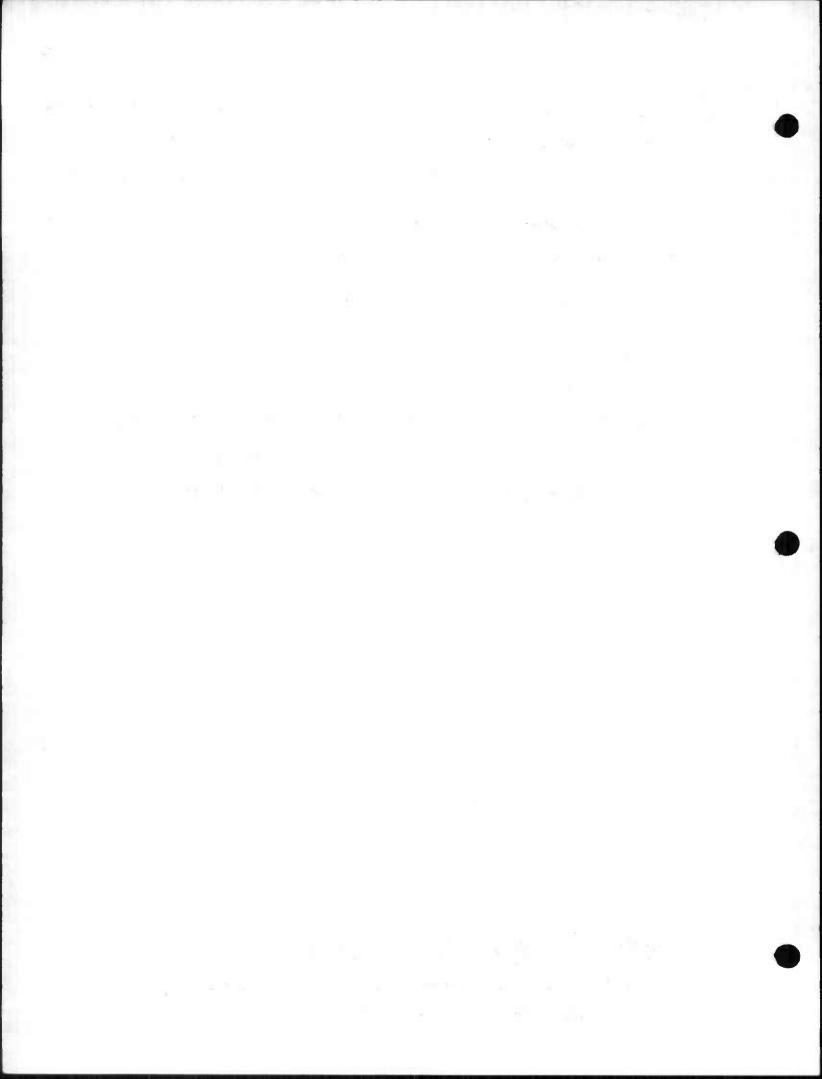
| | | HEGISTRAN CERTIF | ICATE | JE DEATH | REG. NO | | |
|--|---------------|---|-------------------|------------------------------|----------------------------|-----------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) Alice Marie Jones | | | | | 3. TIME OF DEATH |
| | | | | | - | | 96 1037 A M |
| | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) | MONTHS DA | AR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign Country) |
| D D | | 233-38-3152 1□M2ØF 74 YRS. | | | April 1, 19 | V | w. V. |
| should | _ | 9a. FACILITY NAME (If not institution, give street and number) | | WN OR LOCATION OF D | EATH | 9c. COUNTY | |
| 6, | 0 | Union Hospital | EIK | TON | | Ce | 51/ |
| 1 5 | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CI | TY, TOWN OR L | OCATION | | | 10d, INSIDE CITY |
| Pages | <u>E</u> | 1 1 | IKtON | | | | LIMITS? |
| bermit. | | 10s. STREET AND NUMBER | | 10f, ZIP CODE | | 10e. CITIZEN | OF WHAT COUNTRY? |
| ed th | RA | 2944 Singerly Rd. | | 21921 | | | SA |
| 020 physician. burlaf-transit | FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WM.S | | NIC ORIGIN? (Specify Ye | | RACE — American Indian, |
| 020 Ohysic | | 1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | It ye | s, specify Cuban, Maxic | an, Puarto Rican, etc.) | | Black, White, atc. |
| 5-0020 nding physic is the burial | BY | 3 Wildowed 4 Divorced | '' | YES 2 X NO Speci | ny: | | white |
| attend | G | 15. DECEDENT'S EDUCATION 16a. DECEDENT'S (Specify only highest grade completed) (Give kind of | B USUAL OCCU | PATION ng most of working | 16b. KIND OF BU | SINESS/INDUST | TRY |
| 2121 all or afti for use | COMPLET | Elementary/Secondary (0-12) College (1-4 or 5+) | use retired.) | ig most or working | 1 | 1 1 | |
| D spital | AP. | | urse | | // | edic | a |
| AND 2. The hospital of detached for once. | Ö | 17. FATHER'S NAME (First, Middle, Last) | | | AME (First, Middle, Maiden | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | BE C | James A. Bender | | Leolo | M. Mo | The | JY |
| MARN retained to should a should notified | | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILIN | G ADDRESS (Si | | Route Number, City or Tox | | |
| M. e retz e 5 si | 5 | David Jones 2944 | 1 5129 | erly Rd. A | EIKHN, M | 0219 | 121 |
| RE, nay be | | 20a, METHOD OF DISPOSITION 1 & Burlei 2 Cremation 3 Removal from State 20b. PLACE AND DATE camelery, crematory or | | N (Name of | | | or Town, State |
| 1MORE, MARYLAND 21215-0020 Page 6 may be retained by the hospital or attending physician. Il director, page 5 should be detached for use as the burial-tran ner must be notified at once. | - | 1 St. Burial 2 Cremation 3 Removal from Stata Camptery, crematory or 4 Donation 5 Other (Specify) Camptery | emete | 1/ | | | 11, mD |
| TIM Page | | 21. SIGNATURE OF THERAL SERVICE LICENSEE | 22. NAI | ME AND ADDRESS OF F | ACILITY GEE | FUNE | al Home |
| ALTIN death. Pag tuneral di t. | | ADXI. XU | 259 | E. Mais | St. Elkto | w, m | 0 21921 |
| B nours after or removal. | | 23. PART I. Enter the diverses, or complications that caused the death. Do | | | | | , Approximata |
| | | *shock, or heart failure. List only one couse on each line. | 1 | / | | | Onset and Death |
| Sites of the state | | disease or condition | 42 | lure | | | 148ht |
| 7760 ted within completely al. cremat. | | resulting In death) DUE TO (OR AS A CONSEQUENCE | OF): | | | | |
| 6876 ecuted and com burial, | z | COPD. | | | | | |
| CX 9 EB E | CERTIFICATION | Sequentially list conditions, If any, leading to immediate | OF): | | | | |
| | CA | CAUSE (Disease or Injury | | | | | |
| Certifical certifical ding phy hygiene p | | that initiated events resulting in death) LAST | OF): | | | | |
| V 5 5 5 5 | EH | d | | | | | |
| DS, the att d Menta injury, | | PART II. Other algnificent conditions contributing to death but not resulting | In the unde | rlying cause given i | | | 24b. WERE AUTOPSY FINDINGS |
| - VICT - 55 - | EDICAL | 1) COSONNY ALRIY DIVEAS | 1- | | PERFO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 | ED | | | | 1 TYES | 2 1900 | OF DEATH? |
| | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y | ES DE NIC | UNCERTA | INΠ | | 1 TYES 2 NO |
| Speries as the control of the contro | SICIAN: M | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DE | | | | | |
| N: The hoate h | CIC | EXAMINER? 1 YES 2 NO 1 Inpetiant 2 ER/Outpetient 3 DOA | OTHER: | | a D Outre (Desert) | | |
| F VIT. SICIAN: The State of the | PHYS | | - | d. INJURY AT | 2ad. DESCRIBE HOW | INJURY OCCUP | RED |
| NO PHYS with marked | | 1 Natural 5 Pending (Month, Day, Year) | NJURY | WORK? | | | |
| ONING After death | BY | 2 Accident Investigation 3 Sujeide 8 Could not be 28s. PLACE OF INJURY — Al home, term | , street, factory | | 281, LOCATION (Street | | Rural Route Number, |
| ISI THEN after | TED | 3 Suprise 8 Could not be building, atc. (Specify) | | | City or Town, State |) | A 717 |
| DIV OREC DIREC DIREC Item | LET | 29e. CERTIFIER Chark column 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occur | rred at the time | , date and place, and di | ue to the cause(a) and mu | nner se stated. | |
| 보 기 | COMPL | (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation | | | | | |
| HOSI WITHI | 2 | 70% SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE N | UMBER | 29d, DATE S | IGNED (Month, Day, Year) |
| TO THE HOSPIT TO THE FUNER DE filed within ? | PE PE | Vir Samell 11 | | 0.37 | 5,0 | D 1 | -24.96 |
| 5 5 8 S | 7 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Ty) | pe, Print) | 2 | ^ | | |
| | | Tinothy O. Donnell M.D. Vite | 32 | People | Ph 20 /01 | NGO W | De 19202 |
| | | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | |
| | | JAN 26 1996 Juli davaler Revolat | | | | | |
| | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygien 96

| | | | | | | Certifi | cate of | Death | | Re | g. No. | | |
|-------------------------------|---|------------------|---|---|-----------------------|---------------|---------------------------------|-----------------------------------|------------------------|--|--------------------------------|---------------------------|--|
| | | | 1. Decedent's Neme (First, Middle, Le | ist) | | | | | | 2. Dete of Deett | h | | 3. Tima of Death |
| | Physic | | Mary Annie Eli | zaheth | | Jon | es | | | Month Jan. | 18 1 | 998 | 6:00am |
| 1 | /Medi Examir | | 4e. Facility Neme (If not institution, gir | | | - | | 4b. City, To | wn, or Lo | ocation of Deeth | 4c. County | of Death | |
| Æ. | LAGITI | iei | Easton Memorial | Hospital | | | | East | on | | Talbo | | |
| - | Funeral | | | | a (In yrs. last birt | thday) If | Undar 1 Yaar | | | 8. Data of Birth | | | lece (State or Foreign |
| | Director | | 217-30-9839 Usuel Residance of Decedent | I | | | onths Deys | Hours | Min. | 8. Data of Birth (Month, Day, May 27, | Year) 1935 | Coun | yland |
| | Mand Mand | | 10a. Steta 10b. County | | 10c. City, Town | or Locatio | ก | | | | | 1 | Od. Insida City Limits |
| | ould be filed within 72 hours after death with the Meryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show actic event, the Modical Examinat must be notified at | Funeral Director | Maryland Dorche | ster | Vienna | | | | | | | | 1 ☐ Yes 2 No |
| | A S | ä | 10e. Street and Number | | | 10 | Of. Zip Coda | | | 10 | og. Citizen of \ | What Coun | itry? |
| | ath . | rai | 4516 Fork Neck R | | | | 21869 | | | | USA | | |
| | er de | nue | 11. Meritel Status | 12. Was Decedent I Armed Forcas? | | 13. Was | Decedent of I s, specify Cub | dispanic Original Jen, Mexican | gin? (Spo n, Puarto | pecify Yas or No- p Rican, etc.) 14. Race - A Black, W | | | |
| 020 | ral", or | þ | 1 ☐ Naver Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes ②☐XN If Yes, Give Year or Detes: | lo | 101 | ras XXNo | Specify: | | | Specify | /: B1 | ack |
| 5-0 | 72 ho | Completed | 15. Decedent's E (Specify only highest gr | ducation | 18e. | | S Usuel Occup of work dona | | t of work | ina | 6b. Kind of B | usinass/Inc | dustry |
| 7 | thin was | ple | Elementery/Secondery (0-12) | College (1-4or 5 | +) | life. DO N | OT use retire | d) | OF WORK | ii ig | | | |
| 7 | od wi | 50 | 12th | | | Sean | nstress | 5 | | Sewing | | | |
| nd | al Hy | Be (| 17. Fathar's Nama (First, Middla, Last |) | | | | 18. Mothe | er's Neme | e (First, Middle, M | faiden Suman | 10) | |
| <u>Y</u> a | Went Went when | To B | Elwood Molock | | | | | Lo | uise | Pinder | | | |
| altimore, Maryland 21215-0020 | permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelth and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or Nems 23a or 28a-4 show any Injury or other traumatic event, the Mod cal Examiner must be notified at ance. | | 19e. Informent's Neme/Reletionship | Type, Print) | | | | | | n, Maryl | - | State, Zip | Code) |
| ē, | Hee Hee | | 20e. Method of Disposition | | 20b. Place of | Disposition | (Name of | | | - | Oc. Location - | City or To | wn. State |
| no | eges ant of t: If H y or | | 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special | | | | y or other pla | | 1 | | | | |
| Ē | it. P | | 21. Signatura of Funerel Service | | Fort Ne | eck- N | Molock me and Addre | Cemet | ery | /23/96 | Cambri | age, | Md. |
| Ba | Department of the partment of | | 21. Signatura di Funerei Service | 1000 | | | | | | neral Ho | me | | |
| _ | | | /late | | | | | | | Easton, N | | 501 | |
| | | | 23e. Fert1. Enter the disease, or com shock, or heart feilure. List only | plicetions that ceused one ceuse on aech lin | the deeth. Do n a. | not enter the | e mode of dyi | ng, such es | cerdiec (| or respiretory arre | st, | | Approximata Interval Between |
| | Physician / /Medical | | | Λ | - 0 | | | , | 1 | | | Ì | Onset and Deeth |
| | Examiner | | Immediate Cause (Fine) disaasa or condition resulting in death) | · Houl | i m | your | udes | 1 | huf | archio | M. | / | menutes |
| | | - | Tooling in doding | | Due to (or as a o | consequenc | e of): | | | | | | year |
| | ed isit | Examiner | | b. ather | meler | mi | Cor | may | Cirti | y De | read | | year |
| | and I-trar | xan | Sequentially list conditions, Due to (or es e consequence of): | | | | | | | | | | |
| 9 | be e. ician buria | | Cause (Disease or injury | c. Or | abeti | 5 | | | | | | ì | |
| 68760 | intificate be executed ing physician and a es the burial-transit | edical | thet initieted events resulting In deeth) Lest Due to (or es e consequence of): | | | | | | | | | | |
| ox 6 | ding se es | 2 | L L | d | | | | | | | | į | |
| m | eeth ce ettendii for use | ian | | | | | | | | | | | |
| P. O. | The law requires that the deeth ce sta hes been signed by the ettendi page 2 should be detached for use | Physician/ | Pert II. Other significant conditions of | ontributing to death bu | it not resulting In | the underly | ying ceuse gir | ven in Pert t. | | 23b. Did tot | bacco use co | ntribute to | the cause of death? |
| D. | hat ti | | End son | ce. Rinal | 10es | 1111- | | | | 1 □ Ye | s 2 No | 3 Prot | bably Unknown |
| Ś | signe signe d be | I by | End Sta Byputina | | | | | | | | VIII. | T 044 W | AND DESCRIPTION OF THE PARTY OF |
| 0 | neen houk | Completed | Arouting | M | | | | | | 24a. Wes an perform | | ava | ere autopsy findings alleble prior to mpletion of cause |
| ec | hes b | npidu | | ^ | | | | | | | | of e | death? |
| | | Co | | | | | | | | 1 ☐ Ya | s 2000 | 1 🗆 | Yes 2000 |
| E | Physician: The this certificata ral director, pag | Be | 25. Wes cesa referred to medicel examiner? | | | | | 28. Plece | of Deett | (Check only one | 9) | | |
| 2 | ls ce dire | 2 | 1□ Yes >SNo | Hospitel: 1 ☐ Inpatia | nt 2 ER/Out | tpatient 3 | □ DOA Ott | ner: 4/2 Nu | rsing Ho | me 5 Resider | nce 6 Oth | er (Specify | () |
| 0 | g Ph ter thi | | 27. Mengar of Death Naturel 5 Pending | 28a. Dete of Injur (Month, Dey | y 28b. T | ima of | 28c. Inju | ry at | | 28d. Describe hor | w Injury occur | red | |
| Ö | Attending it death. ector: After by the fune | atic | 2 ☐ Accident invastigetion | 1 | | N | | Yes 2□1 | No | | | | |
| Division of Vital Records, | or Attending after death. Director: After | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Plece of Inju- building, etc | ry - At home, fer | rm, street, f | ectory, office | | | 28f. Location (Str. City or Town, | | er or Rura | l Route Number, |
| 5 | tal or Al is aftar al Direc ed in by | Ce | | ounding, old | . (0,000) | | | | | , | ,, | | |
| | To the Hospital of within 24 hours a To the Funeral D completely filled it | edical | 29e. Certifler (Check only one) Cartifying Ph | yalcian: To the best on niner: On the basis of end menner ste | exeminetion end | deeth occu | urred et the tigetlon, in my o | me, dete end opinion, deet | d plece, o | end due to the ce ed et the time, de | use(s) and ma te and plece, | anner as st and due to | eted. the cause(s) |
| | o the | Me | 29b. Signeture end title of certifig | 1/1 | | | 29c. Licens | se number | | 29 | d. Dete signe | d (Month, i | Day, Year) |
| | - 5 - 0 | | Mucho | 1 NAD- | | | 1 | 11200 | 15 | | 1-1 | 0 | 9/ |
| | | | 30. Neme and address of person who | 1 Lyec | 7 47 | Toronto. | U | the | 7) | | /-/ | 0 - | 16 |
| | | | | | | | | a to === | MJ | 21401 | | | |
| | Cha | • | Michael Lees, M 31. Data filed (Month, Day, Year) | 32 Registra | r's Signature | | | ston, | rid. | 21001 | | | |
| | Sta Registr | | JAN 2 | 9 1996 | a divideo | x-Rando | elle | | | | | | |
| | 3 | | | | | | | | | | | | |



Pages 1, 2, 3 should

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page 5 should

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| DIVISION | HOSPITAL OR ATTENDING PHYSICIAN: The law ri |
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| _ | HOSPITAL |

FOR STATE REGISTRAR CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JR. YEAR JOHNSUN JANUARY 22, 1996 HARRY RIDDLE 0108 М 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreign DAYS HOURS 1 🖳 M 2 🗌 F 159-18-0343 73 JAN.31,192 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10e. STATE tod. INSIDE CITY LIMITS? YES 2 NO WICOMICO SALISBURY FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 229 CANAL PARK DRIVE 21801 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 12 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried 1 YES 2 NO Specify Specify: WHITE BY 3 Widowed 4 Divorced ARMY WWII 16a. DECEDENT'S USUAL OCCUPATION

16a DECEDENT'S USUAL OCCUPATION working most of working ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL EPISCOPAL PRIEST MINISTRY once. 17. FATHER'S NAME (First Middle Last) ta, MOTHER'S NAME (First, Middle, Meiden Surneme) HARRY RIDDLE Ħ JOHNSON, SR. ELIZABETH FLICK O'NEILL notified 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 HOPE JOHNSON 229 CANAL PARK DRIVE, SALISBURY, MD. 21801 pe 20e. METHOD OF DISPOSITION

1 Burlet 2X Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must CAMBRIDGE CREMATORY 1/25 CAMBRIDGE, MARYLAND 4 Donation 5 TyOther (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD. ulale medical 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one ceuse on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel the disease or condition Gastric Hemonhoge 2 min resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): arcenoma traumatic C CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE If any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST 0 Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL DIRECTOR: After this certificate has been signed by a hours after death with the State Dept. of Health and Item 28 is marked, or item 23 shows any In Arteriosclerotic Cardiovascular and AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 TH NO OF DEATH? Corebro vascular dissose t TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 YES 2 X NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26 e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending investigation 1 YES 2 NO BY 3 Sulcide 26e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide Item 29e. CERTIFIER (Check only one)

The physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ea attend.

The physician is a support of the physician of the physicia FUNERAL (within 72 h TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(s) end manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 08008 Thomas C Help 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I)EM 27) (Typh. Print)
THOMAS C. H. II J. R. 108 PINE BUFF Road Salisbury 31. DATE FILED (YAN 23 32 MEGISTRAPS SIGNATURED

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygien

Certificate of Death

96 03749

| | | | | | | Cen | ificate o | t Death | | | Reg. N. | | |
|--|------------------|----------------|--|---|--------------------------------|---------------------|-----------------------------------|---------------------------------|----------------------------|---|---------------------------|---------------------------------|---|
| ŧ | Physici | an | Decedent's Neme (First, Middle, Last Harriet | • | eanora | | Jenki | | 1 | 2. Dete of De Month | Dey | Yeer | Time of Death |
| | /Medic | - 2 | 4a. Facility Neme (If not Institution, give | | | | Jenki | | | Jan | - | | :40 Am |
| Ē | Examir | ier | The state of the s | - Die Allica - Frei | | | | | | ation of Death | | | |
| = | | | Collingswood 5. Social Security Number 6. Se | | g HOME ge (In yrs. lest bin | hday) | If Under 1 Yes | | kvil | | h M | ontgon | |
| | uneral rector | | | □ M 2DXF | | Yrs. | Montha Dey | | Min. | (Month, De Feb. 1 | h y, Year) 6 , 1919 | Country) Mary | (State or Foreign |
| | | | Usuel Residence of Decedent | | | | | | | - 0.0 (2 | 0,2323 | 11011 | 20110 |
| | Lat the | | 10a. Stete 10b. County | | 10c. City, Town | | | | | | | | naide City Limits |
| | ill in | cto | Maryland Montg | omery | F | Rock | ville | | | | | 1 | ©(Yes 2 No |
| 04.2 | 9 P | Director | 10e. Street and Number | | | | 10f. Zip Code | | | ļ | 10g. Citizen of \ | | |
| 238 | | | 903 N. Stones | treet A | ve. | | 20 | 850 | | | U.S. | Α. | |
| items 23s or 28s-f show one must be notified at | | Funeral | 11. Meritei Stetus | 12. Wes Decedent Armed Forces | ? | 13. W | as Decedent of Yes, specify Cu | f Hispanic Orl iben, Mexicar | lgin? (Spec n, Puerto R | ify Yes or No- ican, etc.) | | ce - American Inck, White, etc. | idlan, |
| at', or | | by F | 1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Detes: | No | 1[| ☐ Yes ②CM | o Specify: | | | Specify | Blac | k |
| thurs. | | | 15. Decedent's Ed | | 16a | Decede | nt's Usuel Occ | unation | | la de | 16h Kind of B | usiness/Industr | u . |
| n 'ne | | Completed | (Specify only highest grad | de completed) | | (Give ki | ind of work don O NOT use reti | e durina mos | t of working | 9 | 100.11.10.01.01 | 001100011100011 | |
| 100 | | E | Elementery/Secondery (0-12) 12th | College (1-4or | 5+) | Co | ook | | | | St. Ma | ry's C | hurch |
| offhe yent, | | Be C | 17. Fether's Neme (First, Middle, Last) | | | | | 18. Mothe | er's Neme (| (First, Middle, | Meiden Sumen | ne) | |
| rked fice | | 10 | Frederick How | ard | | | | | | | erkley | | |
| la ma | | | 19e. Informent's Neme/Reletionship (7 | ype, Print) | 19b | Meiling | Address (Stre | et end Numb | er or Rural | Route Numbe | er, City or Town, | Stete, Zip Cod | 20850 |
| 11 Z J | | | Henry Jenkins | (Husban | | | | onest | reet | | , Rock | - | |
| or off | | | 20e. Method of Disposition | Removel from State | comotos | Dispost y, creme | tion (Name of story or other p | lece) | | Dete | 20c. Location - | City or Town, | Stete |
| # E | | | 4 ☐ Donetlon 5 ☐ Other (Specify |) | | of | Heave | n Cem | . 2/ | 5 | Silver | Sprin | g, MD |
| importar any inju pnce. | | | 21-Signeture of Funerel Service Ligen: | 500 | 4 | | Name and Add | | | HOME | , P.A. | | |
| _ (| 7 | - | SINCE K. | / Ohn | ndu | P | OCKVI. | LLE, | MD : | 20850 | | | |
| 1.52 | | | 23s. Part1. Enter the disease, or corpo shock, or hear failure. List only of | lications thet cause me ceuse on eech i | d the deeth. Do r | ot enter | the mode of d | ying, such es | cardiec or | respiretory e | rrest, | Inte | roximate rvel Between |
| sicia edic | | | tunned at Course Wheel | | | | . 1 = | -10 | - | 0.4.1 | | | set and Death |
| mir | | | Immediate Cause (Final disease or condition resulting in death) | MYOCI | 4201K | K | INF | THRE | -110 | | | 1/ | IMED |
| | WIII) | 6 | | MYOCI ARTE INSUL | Due to (or es e | consequ | ence of): | 77.0 | 1111 | ~ . 1 . 1 | n DI | | |
| T SE | | Examine | | HRIE | 12/09 | -4 | 5/60 | 1/6 | VHS | CULIT | TC VIS | ENSE | |
| ician and | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | 1116111 | IN DE | 70 L | WIN A | 117 | DI | ABE | TIC | | |
| yaid he bu | | edical | Cause (Disease or Injury that initiated events resulting in death) Last | 110 100 | Due to (or es e d | onseque | ence of): | | VI | 1110 | //- | | |
| ng pt | | Med | remaining in dealthy case | Ø. | | | | | | | | i | |
| tendi | N E | an/M | - | ď. | | | | | | | | Ì | |
| the atto hed for | Total I | Physician | Pert II. Other algnificent conditions co | ntributing to death t | out not resulting in | the und | terlying cause | given in Pert i | 1. | 23b. Dld 1 | lobacco uae co | ntribute to the | cause of death? |
| 64 | | | | | | | | | | 10 | Yee 2 No | 3 Probably | 4 ☐ Unknown |
| 8.8 | | by | | | | | | | | | | 1 | |
| been s should | | Completed | | | | | | | | 24e. Wes perfo | en eutopsy rmed? | eveileb | utopsy findings le prior to tion of cause |
| TO CH | | ldu | | | | | | | | | | of death | 17 |
| | | 8 | | | | | | | | 101 | res 2□ No | 1 🗆 Yes | s 2□ No |
| certificate ractor, pay | | Be | 25. Was case referred to medical examiner? | Hospital: | | | | | | (Check only o | | | |
| 100 | 1 | 10 | 1 Yes 2 No 27. Manner of Death | 1 🗆 Inpati | | | 3LI DOA | | | | dence 8 Oth | | |
| N S | | ion | 1 □Natural 5 □ Pending | 28s. Date of Inj. (Month, Da | | ime of njury | 28c. in W | jury et /ork? □ Yes 2 □ | | so. Describe i | now injury occur | red | |
| y the | | lcal | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be | 28e Piece of In | iun - At home fe | em etros | | | | Rf Location / | Street and Numb | her or Rural Roi | ita Number |
| Director: In by the | | Certification: | 4 Homicide determined 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) | | | | | | 20 | 28f. Location (Street end Number or Rural Route Number, City or Town, State) | | | |
| Funeral D stoly filled | | | 29s, Cartifler (Cartifying Phy | rsician: To the best | of my knowledge | deeth d | occurred at the | time, dete en | nd place, an | nd due to the | ceuse(s) and me | anner as stated | |
| in Fun plately | | edical | | nar: On the basis of end manners | of examinetion and | | | | | | | | |
| To the comple | | Me | 29b. Signature and State of certifier | 100 | 1/1 | | 29c. Lice | nse number | | | 29d. Date signe | d (Month, Dey, | Year) |
| A District | | | 1000 | 7/4 | 1/1/1 | 0 | D | 0112 | -0 | | JAN | 31 | 1996 |
| | | | 30. Neme end eddress of person who c | ompleted sause of | deeth (Item 23e) (| Type, P | | | | | | | . , , - |
| | | | Walter E Goo | ozh. M.D | . 2309 | Sho | | ld Rd | l., W | heato | n, MD | 20902 | |
| | Sta | te | 31. Dete filed (Month, Dey, Year) 199 | G 3 Regis | er's Signetur Pa | La II. | | | - | | | | |
| ₹e | gistr | ar | FED UM 133 | July 1 | | A 42. I | | | | | | | |
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 96

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| | | | | | Cer | tificate | of D | eath | | Reg. No. | | |
|--|----|--|--|---------------------------------|-----------------------------|--|---------------------|--|--------------------------------------|----------------------------|---------------------------------|---|
| 60 | | 1. Decedant's Nama (First, Middla, Las | t) | | | | | | 2. Data of Do | | Vees | 3. Time of Deeth |
| Physician /Medical | | Benjamin | Franklin | | Jacol | bs | | | Januar | v 30 | 1996 | 5:30 AM |
| Examiner | | sa. Facility Nema (If not institution, giva | street and number, |) | | | 4b. | City, Town, or I | | | County of Dea | |
| | ı | 7215 15th Avenue | | | | | Т | akoma P | ark | Pr | ince G | eorges |
| Funeral | | 5. Social Security Number 8. Se | | ga (In yrs. le | st birthdey) | If Undar 1 \ | /ear | If Under 24 Hrs. | | | | thplaca (Stata or Foreign buntry) |
| Director | | 573-30-5163 | | 72 | Yrs. | Monthe D | ays | Hours Min. | Jan 4, | | | ssouri |
| 8 11 | | 10a. Stata 10b. County | | 10c. City, | Town or Lo | cation | | | | | | 10d. Insida City Limits |
| 는 교 이 | | Maryland Prince | Georges | т | akoma | Dark | | | | | | 1 ☐ Yas 2 ☑ No |
| 1 S | 3 | Oe. Street and Number | ocorges | | anoma | 10f. Zip Co | oda | | | 10a. Citiza | en of Whet Co | ountry? |
| 0 | | 7215 15th Avenue | | | | 2091 | | | | | | , |
| era era | - | 11. Meritei Stetus | 12 Was Decedant | Evar in U.S. | 13 V | | | nanic Origin? (S | necify Vas or N | USA | 4. Race - Ama | rican Indian |
| any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | | 1 ☐ Nevar Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced | 12. Wes Decedant Armed Forces? 1 ☑ Yes 2 ☐ If Yas, Giva Yaar or Datas: | No | | Yas, specify | | panic Origin? (S Maxican, Puert Specify: | o Rican, etc.) | | Bleck, White Specify: Wh | a, atc. |
| Be Completed | | 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) | ucation fa complated) Collega (1-4or | 5+) | (Giva | lant's Usuel O kind of work o DO NOT use r | iona du | ion ring most of wor | king | | d of Business | |
| F O | | 11 | | | Sei | rvice N | | - | | | | Machines |
| e e | | 17. Fethar's Nama (First, Middla, Last) | | | | | 1 | 8. Mother's Nan | na (First, Middle | a, Maidan S | Sumame) | |
| 2 0 | | Rolla Cluff | | | | | | Nellie | Jacobs | | | |
| 5 | | 19e. Informant's Name/Ralationship (7 | ype, Print) | | 19b. Mailin | g Addrass (S | treet an | d Number or Ru | iral Routa Numi | ber, City or | Town, State, | Zip Code) |
| or th | | Margaret L. Jacob | S | | 7215 | 15th A | Aven | ue. Tak | oma Par | k, MD | 2091 | 2 |
| y or oth | 1 | 20e. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cramation 3 ☐ I 4 ☐ Donation 5 ☐ Othar (Specify, | | cer | natary, cren | sition (Nama enetory or other | r plece) | Cemeter | Data 2/5/96 | | ation - City or | |
| n l | - | 21. Signature of Funaral Service Licens | | Hai | - | . Name end A | | | . y | CIOWI | ISVILLE | , FID |
| an y | | | 11:10 | 2 | Fı | rancis | J. | Collins | | | | |
| | + | 220 Part Sploy the disease of the | 400 | d the death | | | | ity Blv | | | er Spr | ing, MD Approximate |
| cian dical niner | Ì | 23a. Part1. Enter the diseese, or comp shock, or haert failura. List only o tmmediata Causa (Final diseesa or condition rasulting in daath) | Metast | astic | Color | n Cance | | | | | | Interval Between Onset and Death |
| <u> </u> | | | | Dua to (or | as a conseq | uance of): | | | | | | |
| s the burieltransit | | | b | | | 3 | | | | | | |
| XS XS | 1 | Sequentielly list conditions, if any, leading to immadiata causa. Entar Undarlying | | Dua to (or a | as a conseq | uance of): | | | | | | |
| D G | 1 | Causa. Entar Undarlying Causa (Disaase or Injury that initieted evants | c | | | | | | | | | |
| as the bur | | rasulting in death) Last | | Due to (or a | s e consequ | uanca of): | | | | | | |
| 9 2 | | L. | d | | | | | | | | | |
| for us | | | | | | | | | | | | |
| Physician. | | Pert II. Other significant conditions co | ntributing to death b | out not rasult | ing in tha ur | ndarlying caus | a givan | in Part I. | 23b. Did | tobacco u | ee contribute | to the cause of death? |
| Ph) | | | | | | | | | 1□ | Yee 2 | No 3□P | robably 40 Unknown |
| 2 2 | | | | | | | | | | | | |
| should ieted | | | | | | | | | 24a. Wa: perf | s an autops ormed? | ' | Wera autopsy findings evailable prior to completion of cause of death? |
| rector, page 2 | | | | | | | | | 10 | Yas 2 | No | 1 ☐ Yas 2 ☐ No |
| director, g | | 25. Wes casa referred to medical | | | | | - 2 | 26. Placa of Dea | ath (Check only | ona) | | |
| To | | axaminar? 1 ☐ Yas 2 ☑ No | lospital: 1 ☐ Inpati | ent 2 🗆 E | R/Outpatien | t 3□ DOA | Othar: | 4□ Nursing H | ome 5 🖾 Res | Idence 8 | Othar (Spe | cify) |
| funera tion: | | 7. Mannar of Deeth 1 ☑Netural 5 ☐ Panding 2 ☐ Accident invastigation | 28a. Data of Inju (Month, Da | | 8b. Tima of Injury | | Injury a Work? | | 28d. Dascribe | | - ' | |
| by the | | 3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homlcida datermined | 28a. Piace of In building, et | jury - At horr lc. (Specify) | a, farm, stre | eat, factory, of | ffice | | 28f. Location City or To | (Street and own, Stata) | Number or R | ural Routa Number, |
| completely filled in | | 29a. Cartifier 1⊠ Certtfying Phy (Check only one) 2 Medicat Exami | sician: To the best ner: On the basis o end menner st | axaminatio | edge, daeth n and/or inv | occurred at the | ha tima, my oplr | , data and place nlon, deeth occu | , and dua to the rred et tha time | causa(s) a , deta end p | and mannar as place, and due | s stated. a to the cause(s) |
| Me Me | | 50. Signatura and titla of certifiar | | | | 29c. Li | icanse r | number | | 29d. Dete | signed (Mont | th, Day, Year) |
| | | I mardy (|)_1200G | 42/ | w | | | | | | | 1001 |
| | - | o Name and Add at the Control of the | | 0 | | | 3743 | | | Janu | ary 30 | , 1996 |
| | 1; | 0. Nema and addrass of person who co | | | | | | | #00F | | | - 00=== |
| | | Martin David Welt | z M.D. / | 045 G: | reenwa | ly Cent | er | Drive, | #205, G | reenb | elt, M | D 20770 |

Registrar

FEB 02 1996 337 Begistar's Stonature Reveals

DHMH 16 Rev 6/95

3. TIME OF DEATH

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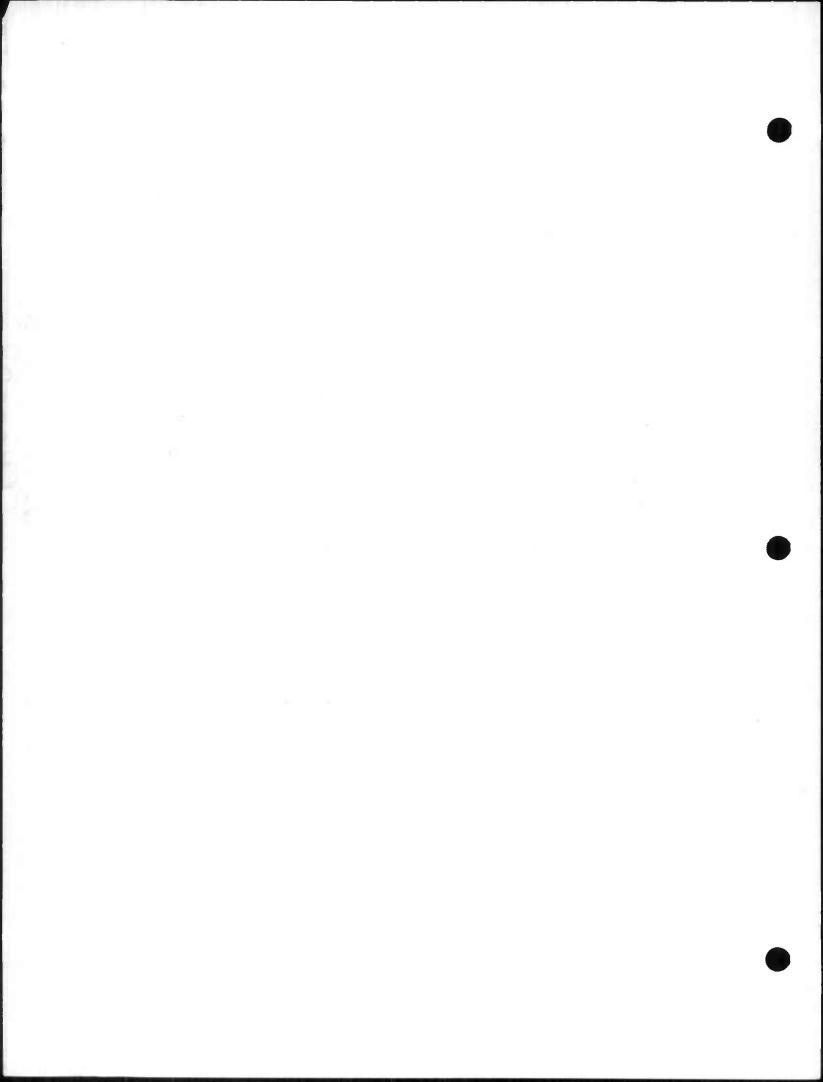
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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2. DATE OF DEATH YEAR Mathew F. Joffre 1996 January 28 10:15 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7, DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 🖫 M 2 🗆 F 194-09-8749 97 Feb. 28, 1898 Spain Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR Sylvan Manor Health Care Center Silver Spring Montgomery 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring Maryland Montgomery 1 TYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1220 East West Highway 20910 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14, RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TYES 2 DO NO Specify: BY Specify 3 🖾 Widowed 4 🗌 Divorced White ETED. 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Chef Food Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Gabriel Joffre Isabel Joffre 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 2 <u>Louise Joffre</u> 1220 East West Highway Silver Spring, Maryland pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must 1 Burial 2X Cremation 3 Removal from State Donation 5 - Other (Specify) Metropolitan Crematory 1/29/96 Alexandria, Virginia examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. LAUNKE 500 University Blvd., W. Sil.Spr., MD completely filled in by the ial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliura. List only one cause on each lina. interval Between 6 IMMEDIATE CAUSE (Final Onest and Death the disease or condition FAILURE ESPIRATORY DUE TO (OR AS A CONSEQUÊNCE OF): event. resulting in death) burial, VEUMONIA DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION and Sequentially list conditions, prior to if any, leading to immediate attending physician cause. Entar UNDERLYING CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST 0 the atten PARX II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 244. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL been signed by the pt. of Health and N KHE UMATIOD any COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? Shows 2 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO L UNCERTAIN I PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item certificate h EXAMINER? HOSPITAL OTHER:
4. Nursing Home 5 - Residence 8 - Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 10 27, MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY After Investigation ATTENDING 3 Sulcide 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be datarmined COMPLETED DIRECTOR: nours after 4 Homicide tem OB 29a. CERTIFIER (Check only one) Descripting Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. THE FUNERAL [= HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as started. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER BE 9 30. NAME AND ADDRESS OF PERSON PLETED CAUSE OF DEATH (ITEM 27) (Type, Prin GEORGIA 090 32 REGISTRAR'S SIGNATURE Julia Davidson Randall 31. DATE FILED (Month, Day, Year) JAN 30 1996 **DHMH-18 Rev 1/89**

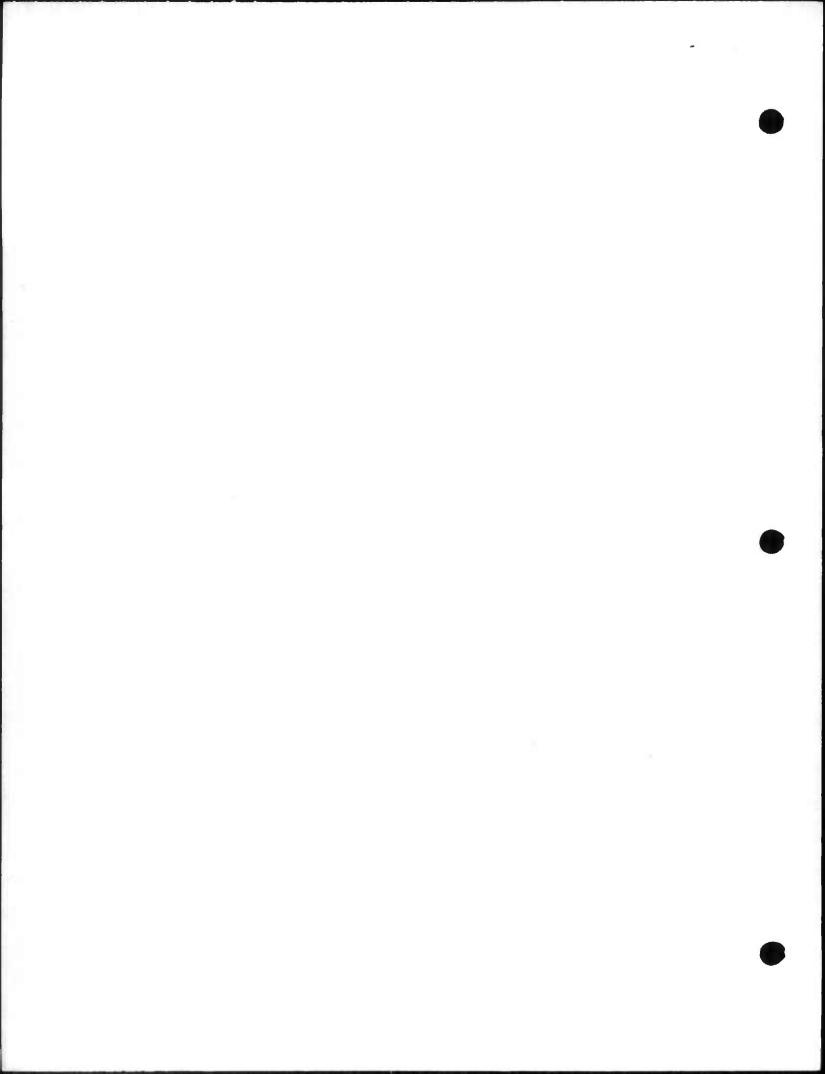
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Page be fleed within 72 hours after death with the State Debt, of Health and Mental Hydere prior to buriat, certainly. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law rec | TO THE FUNERAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of | IMPORTANT: If item 28 is marked, or item 23 sh |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | | | MENTAL HYGIENE REG. NO. | | | | | | |
|--|---|--|------------------------|-------------------|---|---|-----------------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | T | K | | - 0 | 2. DATE OF DEATH | YEAR | 3. TIME OF DEATH | | | | |
| | 4. SOCIAL SECURITY NUMBER | Leon 5. SEX 8. AGE (| In yrs. last birthday) | F UNDER 1 YEAR | Sr IF UNDER 24 HRS. | 7. DATE OF BIRTH | 96 | PLACE (State or Foreign | | | | |
| | 220-07-5871 | 1 M 2 □ F 7 | 3 YRS. | ONTHS DAYS | HOURS MIN. | Oct 12,192 | I Gounn | "Maryland | | | | |
| ш | 9a. FACILITY NAME (If not institution, give a | treet and number) | | 9b. CITY, TOWN | R LOCATION OF D | EATH 90 | COUNTY OF D | EATH | | | | |
| CTO | PENINSULA RECIONAL MEDICAL CENTER SALISBURY WICOMICO 108. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 106. INSIDE CITY | | | | | | | | | | | |
| DIRECTOR | Maryland Dorchester Cambridge 106. COUNTY 106. CTV, TOWN OR LOCATION 107 | | | | | | | | | | | |
| | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT C | | | | | | | | | | | |
| FUNERAL | 2901 Sloop Road 21613 US | | | | | | | | | | | |
| ВУ | 1 Never Married X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? A. YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | ENDENT OF HISPA ecity Cubers, Mexico X X NO Speci | NIC ORIGIN? (Specify Yes or N In, Puerto Rican, etc.) ly: | 14. RACE Black Specif | - American Indian, t, White, etc. by: White | | | | |
| 밀 | 15, DECEDENT'S EDU- (Specify only highest grade | CATION completed) | 16a, DECEDENT'S U | rk done during mo | | 16b. KIND OF BUSINE | SS/INDUSTRY | | | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | We. Do NOT use | e Weav | er | Manui | factur | cturing Plant | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | <u>-</u> | | | ME (First, Middle, Melden Surn | eme) | | | | | |
| BE | James Lee Kin | namon | 10h MAII INO A | DDBERG (Charles | | Ssie Callov Route Number, City or Town, St. | _ | | | | | |
| 임 | Sylvia M. Kin | namon | | | | Cambridge, | | and 21613 | | | | |
| | 20s. METHOD OF DISPOSITION 1 M Buriel 2 Cremation 3 Rem | oval from State 20b. | PLACE AND DATE OF | DISPOSITION (Na | me of | DATE 20c. LOCATIO | ON — City or To | ck, Maryland | | | | |
| | 21. SIGNATURE OF UNERAL SERVICE MC | CENSEE | d. Vete | | emetery | | Lock, | Maryland | | | | |
| | > John) H | me | | Thom 700 | as Fune Locust | eral Home, St. Cambri | P.A. | Md. 21613 | | | | |
| | 23. PART ¹ . Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heert failure. List only one cause on each fine. Approximate interval Between | | | | | | | | | | | |
| | IMMEDIATE CAUSE (First | | | | | | | | | | | |
| | resulting in death) | resulting in death) a | | | | | | | | | | |
| NO. | Sequentially list conditions, (a Korn Arty My fory 1) Jeans | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | Recent | My | | | In tarcha | | 24ha, | | | | |
| TIE | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| CE | PART II Other significant condition | d. | | | | | | | | | | |
| 3 | PART II. Other algnificant condition | | it not resulting in | the underlying | cause given in | PERFORMED | ? | AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| MEDIC. | | | | | | 1 □ YES 2 X | NO | OF DEATH? | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN | | | | | | | | | | | | |
| SICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | 6 Beeldence | 8 Other (Specific) | | | | | | |
| ON MANUEL OF OFFICE | | | | | | | | HOW INJURY OCCURED | | | | |
| BY | | | | | | | | | | | | |
| 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Rou City or Town, Stele) | | | | | | | | | | | | |
| 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) | | | | | | | | | | | | |
| 29c. LICENSE NUMBER 29d. DATE SIGNED (M | | | | | | | | | | | | |
| 2 | 36. NAME AND ADDRESS OF PERSON WHI | | | | , , | 0. | 1-11 | | | | | |
| | 31 DATE EN ED (Month Day Mart) | ELAND MD 32/ARGISTAR'S SIGNA FILLA DIVILLE | 560 | KIVE | 251D9 | DRIVE, JAI | SBUN | MD. | | | | |
| | 31. DATE FILED MONT. 2. 9 1996 | Jama arabetes | - Warbally | | | | | | | | | |



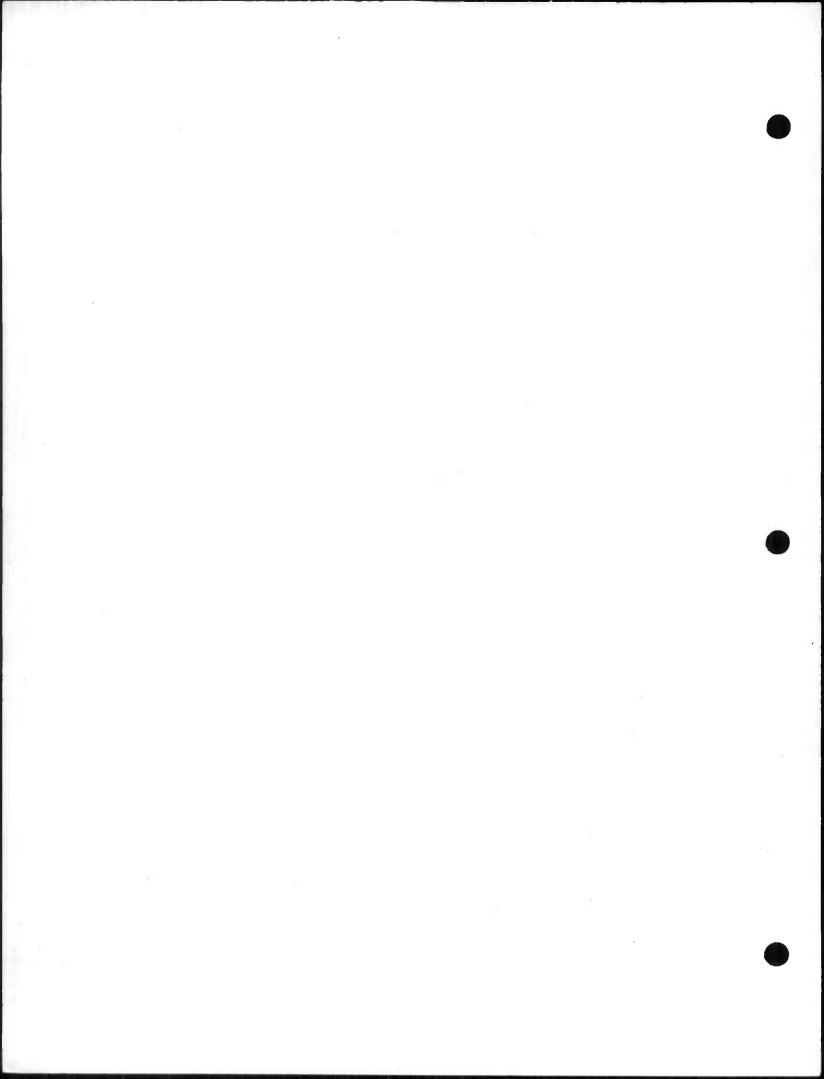
DIVISION OF VITAL RECORDS, P.O. BOX 68760

DIVISION OF VITAL RECORDS, F.C. 2000.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health, and Mental Phygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARY | | | | EALTH AND | MENTAL HYGI | | | | |
|---|--|---|-----------------------------------|------------------------|----------------------|-----------------------------|--------------------------------------|----------------|-------------|---|--------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | |
| · | RUTH ELIZAF | BETH KEITE | R | | | | JANUARY | 28, 1 | 996 | 4:15 | PM |
| | 4. SOCIAL SECURITY NUMBER | 0.5 (0.1) | E (In yrs. lest birthda Ω7 YRS | MONTHS | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yea | r) | Count | NPLACE (State or Foreity) | gn |
| | 528-32-2856 9s. FACILITY NAME (If not institution, give s | 1 M 2 F | 87 YRS | | 704010 | R LOCATION OF D | January3 | | | | |
| | Sacred Heart Hos | Colored Colored | | | berl | | EAIN | | egan | | |
| | RESIDENCE OF DECEDENT | | | | | | | AII | egan | У | |
| | 10a. STATE 10b. COUNT | | | CITY, TOWN | | ON | | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland Alleg | any | Cu | ımberl | | ZIP CODE | | I 10= CF | FIZEN OF I | 1X YES 2 NOWHAT COUNTRY? |) |
| | 601 Bedford Stree | ı t | | | | 1502 | | | S.A. | WHAT COUNTRY? | |
| | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | R IN U.S. ARMED | 13. | WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specif | y Yea or No- | 14. RAC | E — American Indian, | |
| | 1 Never Married 2 Married 3 X Widowed 4 Divorced | FORCES? 1 YE | DATES 1 | | If yes, spe 1 YES | | an, Puarto Rican, etc. fly: | .) | 100000 | k, White, etc. | |
| | 15. DECEDENT'S EDU | ICATION . | te- proppri | | | | | | | *************************************** | |
| | (Specify only highest grade completed) (Give kind | | | | during mos | n it of working | 16b. KIND OF | BUSINESS/IN | DUSTRY | | |
| | 12 | Elamentary/Secondary (0-12) College (1-4 or 5+) Teacher | | | | | Scho | ol | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTNER'S NA | AME (First, Middle, Ma | iden Sumeme) | | | |
| | | eichman | | | | Grace | Snyder | | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 100000 | | | | Route Number, City of | | | 0.0.00/1 | 0 |
| | Joyce L. Taylor | | DIUI 20b. PLACE AND DA | | - | | | naries | | S.C. 2941 | .8 |
| | 1 S Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | noval from Stata | cematary, crematory | or other placel | | | | | | ,Maryland | 1 |
| | 21. SIGNATURE OF FUNERAL SERVICE LA | | - II | 22. | NAME AN | D ADDRESS OF F | ACILITY | | Lanu | , rial y Laire | |
| 1 | - Semmen 4 | Cay ITTEN | M | | | | s Funeral Street, C | | 2001 | 21502 | 2 |
| | 23. PART i. Enter the diseases, or | | | | | | | | _ | Approximate | |
| } | shock, or heart failure. iMMEDIATE CAUSE (Fine) | • | | | , | | | | | Onset and I | |
| | disease or condition resulting in death) | Congeste | in Hear | 1 - | all | w | | | | TEN U | cary |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause for immediate cause f | | | | | | | | | | Edo |
| | | MM | MAdial | Tal | and | 144 | 0 | | 70 | | |
| | CAUSE (Disesse or Injury that initiated eventa | DUE TO (OR A | S A CONSEQUENCE | E OF): | and hou | QVV | | | | 1009 | tells. |
| | reaulting in deeth) LAST | | | | | | | | | | |
| | PART II. Other algolificant condition | ns contributing to deat | h but not resultir | ng in the u | nderlylng | ceuse given in | Part I. 24s. WA | S AN AUTOPS | 241 | . WERE AUTOPSY FING | HNGS |
| | TRICURPIS | REGURE | MATION | | | | 1 225 | REPORMED? | | AVAILABLE PRIOR TO | |
| | GASTROSSAPH | | | | | | | | | OF DEATH? | |
| | DID TOBACCO USE CONT | | OF DEATH | YES 🗆 | NO D | UNCERTA | IN 🗆 | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF D | OTHE | , , | | | | | | |
| | 1 YES 2 NO | 1 Seinpatient 2 ER/C | | A 4 🗆 Nu | rsing Nom | | 8 Other (Specify) | | | | |
| | 1 Natural 5 Pending | 28s. DATE OF INJUF (Month, Day, Yes | | TIME OF INJURY M | | RK? | 28d. DEŞCRIBE N | OW INJURY O | CCURED | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be | 28s. PLACE OF INJU | JRY — At home, fer | m, street, fac | | | 281, LOCATION (S | treet and Numb | er or Rural | Route Number, | - |
| | 4 Nomicide 6 Could not be determined | building, atc. (5 | Specify) | | | | City or Town, | State) | | | |
| | 29a. CERTIFIER 1 CERTIFYING PNYS | SICIAN: To the beet of my kr | nowledge, death occ | curred at the | time, date | end place, and du | e to the ceuse(e) end | I manner es at | ated. | | |
| | anal 6. | | | | | s) and menner ea stat | ed. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER | | | | | | | JMBER | 29d. DA | TE SIGNE | D (Month, Day, Year) | |
| | 7484 | lho | | | | D269 | 867 | ▶JA | ANUAF | RY 29, 19 | 96 |
| | 30. NAME AND ADDRESS OF PERSON W | 10 COMPLETED CAUSE OF | - 179 | | 1 12 | - | | 1 110 | - | | |
| | Harjit Sanu | L32. REGISTRAR'S S | Bishop | Wals | L Ro | rad Lu | mberlan | MA | 213 | 205 | |
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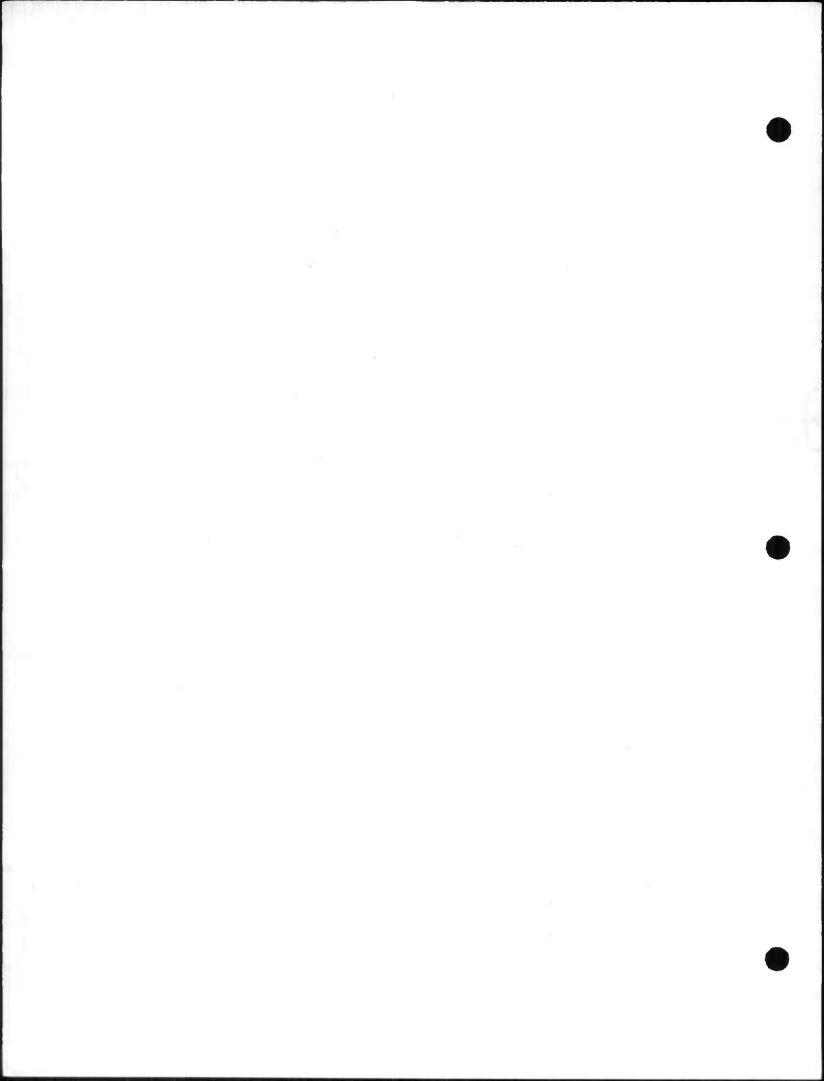
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH January 25, 1996 KENNEDY IVA 10:40 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Yber) B. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 1 | M 2 F 213-12-9054 Aug 31 MD 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH Memorial Hospital & Medical Center Cumberland Allegany DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Allegany Cumberland YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 308 Pennsylvania Avenue 21502 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yee, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried Specify: BY 3 Wildowed 4 ☐ Divorced white ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementery/Secondary (0-12) College (1-4 or 5+) COMPL Former Employee Dept. Store Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Ħ Wilkie Collins Emma (Potts) BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Robert L. Volk 308 Pennsylvania Avenue; Cumberland, MD 21502 be 20a. METHOD OF DISPOSITION

X Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must L 01/28 Cumberland, MD 4 Donation 5 Other (Specify) Hillcrest Burial Park examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home anes Cumberland, MD 21502 23. PART I. Inter the diseases, or complications that caused the death. On not enter the mode of dying, auch as cardiac or respiratory arrest, hock, or heart fellure. List only one cause on each line. medical Approximata interval Between IMMEDIATE CAUSE (Final **Onaet and Death** other traumatic event, the disease or condition Year Small Cell Cancer Lung With Brain Metastasis resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? llem mell HOSPITAL: OTHER: Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 2 Accident TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR; After this be filed within 72 hours after death wi IMPORTANT; If Item 28 is marke 5 Pending 1 YES 2 NO BY investigation 28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) ETED 6 Could not be 4 Homicide 29e. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Ilms, date end place, and due to the cause(e) and manner se stated. COMPL 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year, BE D25406 January 26, 1996 lum M 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. W. Lamm 47 Virginia Avenue Cumberland, Md. 21502 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Jaha Musica Pariet

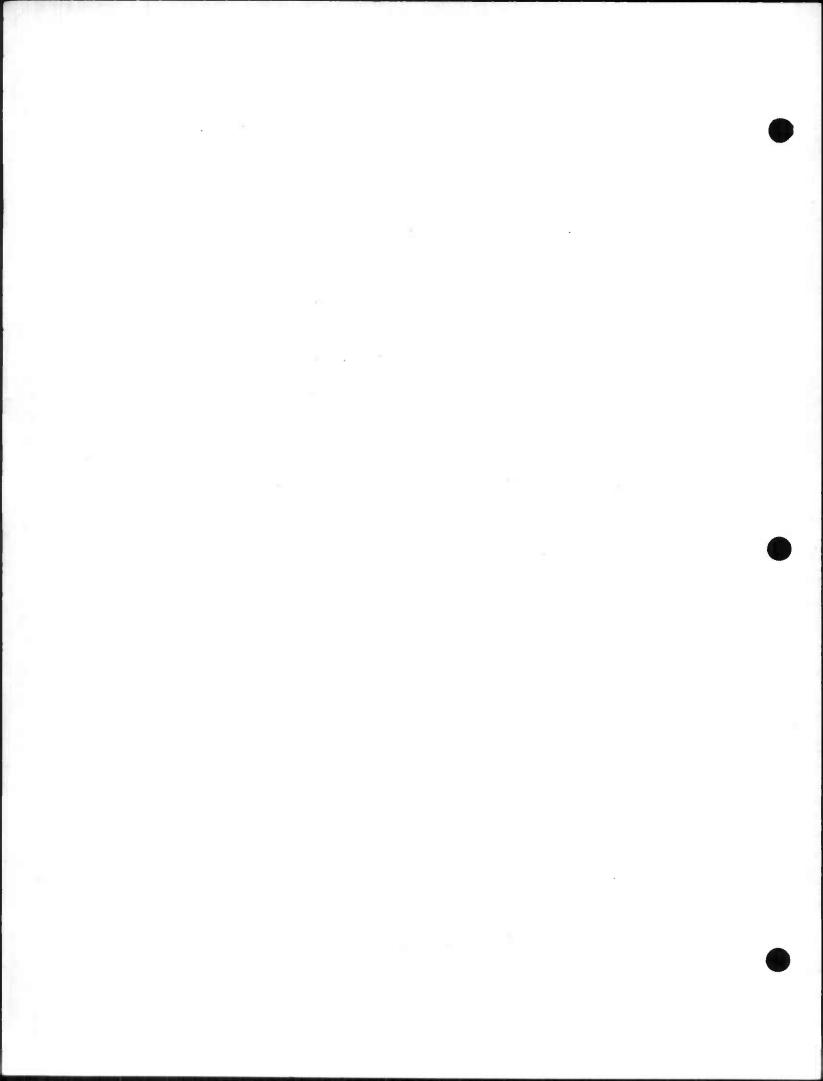


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL OHRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | RTMENT OF | | | MENTAL | HYGIENI BEG. NO. | E | | |
|------------------|--|--|-------------------------|-----------------------------------|----------------|-----------|-----------------------------|--|--------------|-----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 0 | Kestle | er | | | MONTH | OF OEATH DAY | 19.19 | YEAR 3. | TIME OF GEATH |
| | | | 'In yrs. last birthday) | IF UNDER 1 YEA | | R 24 HRS. | 7. DATE C | | | | ACE (State or Foreign |
| | 210 01 0001 | / | 79 YRS. | MONTHS DAT | HOURS | MIN. | - 7.7.7 | 6, 19 | 16 | | yland |
| _ | 9a. FACILITY NAME (If not institution, give street | t and number) | | 9b. CITY, TOV | N OR LOCAT | ION OF O | EATN | | 9c. COUNT | Y OF OEA | TN |
| DIRECTOR | St. Agnes Hospital | | Baltimore | | | | | | | | |
|) H | 10a. STATE 10b. COUNTY | | 10c. Cl | TY, TOWN OR LO | CATION | | | | | 10 | od. INSIGE CITY |
| | Maryland Balti | more | Ca | tonsvi l | le | | | | YES 2 NO | | |
| IAL | 10e. STREET AND NUMBER | W. air Cool | | | | | | | 10g. CITIZE | EN OF WHA | AT COUNTRY? |
| FUNERAL | 719 Maiden Choic | | | | 2122 | 28 | | | USA | 1 | |
| J. | | Name Married 2 Married FORCES? 1 YES 2 | | | | | NIC ORIGIN? en, Puerto R | (Specify Yes lcan, etc.) | or No— 1 | 4. RACE — Black, V | - Amarican indian, Vhite, etc. |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES 13 | 1 🗆 | ES 2 XNO | Specif | y. | | | Specify: | White |
| 8 | 15. OECEOENT'S EQUICATION 16e. OECEOENT'S USUAL OCCUPATION 16h. KIMO OF BUSINESS/MONISTRY | | | | | | | | | | |
| COMPLET | (Specify only highest grade cor | College (1-4 or 5+) | ille. Do NOT u | work done during use retired.) | most of worki | ng | | | | | |
| MPI | 12 | 4 | Mechan: | ical En | gineer | • | | Aero-s | pace | | |
| 00 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | iddle, Malden | Surname) | | |
| 8 | Louis Kestle | er | | | | | oeth (| The second secon | | | |
| 2 | James B. Kestler | | | G AOORESS (Str | | | | | | | 1 3 |
| | 20s. METHOD OF DISPOSITION | 200 | | Clark | | oad, | | | | | |
| | 20e. METHOD OF DISPOSITION Comparison 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Wood lawn Memorial Park Jan, 23, 1996 Easton, MD. | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE / | odiawii i | 22. NAM | ANO AODRE | SS OF FA | CILITY | , 1990 | Ea | ston | , IVID. |
| | retainson C | Line | 0 | | | | | d Fune | | | |
| | 23. PART I. Enter the diseases, or con | pollostions that cause | d the death Oc | | | | | St. M | | | Approximata |
| | shock, or heart fellure. Lis | | | not enier the | mode or dy | mg, suc | on an cure | ac or reapn | atory arre | Φ ί, | Interval Batwean |
| | IMMEDIATE CAUSE (Final disesse or condition | Pur. | . / | | | | | | | | Onset and Death |
| | resulting in death) a. INEUTONIA OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | Iweek | |
| z | Sequentially, list conditions b. | | | | | | | | | | |
| 15 | Sequentially list conditions, If any, leading to immediata OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | | | | | | | | | | |
| Ü | d | | | | | | | | | | |
| CAL | PART ii. Other significent conditions of | | out not resulting | in the under | ying ceuse | given In | Part I. | 24a. WAS AN | | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| 음 | lung CAN | ICER | | | | | | 1 TYES 2 | NO | | OMPLETION OF CAUSE F DEATH? |
| ₹ E | | | | | | | | | | 1 | YES 2 NO |
| ä | DID TOBACCO USE CONTRIE | BUTE TO CAUSE C | | | | CERTAI | NZ | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DE | OTHER: | | | | | | | |
| ΤΥS | 1 YES 2 NO 1 | Inpatient 2 ER/Outs | petient 3 DOA | 4 Nursing | INJURY AT | lealdence | T | (Specify) CRIBE HOW IN | HIRV OCCI | IDEO | |
| | t Naturel 5 Pending | (Month, Day, Year) | 16 | JURY | WORK? | □ NO | 200. DE 3 | CHIDE HOW II | TONT OCCU | MEO | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | — At home, ferm, | | | | | TION (Street a | and Number o | r Rural Rou | te Number, |
| COMPLETED | 4 Homicide determined | building, atc. (Spec | city) | | | | City o | r Town, State) | | | |
| 1 | 290. CERTIFIER 1 CERTIFYING PHYSICIA | AN: To the best of my know | rledge, death occur | red at the time, | tate and place | e, and du | e, to the cau | e(a) and man | ner se state | d. | |
| ₩ O | one) 2 MEDICAL EXAMINER: | | | | | | | | | | nd manner as stated. |
| E C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | - | 29c. LIC | ENSE NU | MBER | T | 29d. DATE | SIGNEO (N | forith, Day, Year) |
| (00 | Roy Habib | U.D. | | | Po | 753 | 6 | | ▶ JA | NUOI | 24 19 1996 |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO C | Carrie Alice | ATH (ITEM 27) (Typ | e, Print) | 410 | | 4.7.2.1 | Δ.1 | c 121 | 1171 - | 1000 |
| | ROY HABIS 11.0 | 1 | | TIIML | -100 | 20 | 212 | 29 AV | U 131 | 10111 | -V N E |
| | JAN 2 3 1996 | 32. DEGISTRAR'S SIGN | or Rarbell | | | | | | | | |



3. TIME OF DEATH

10d, INSIDE CITY

1 X YES 2 NO

Approximate

AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

Interval Between Onaet and Death

PM

8:18

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

2

1 X Natural

3 Suicide

2 Accident

5 Pending

Investigation

burial-transit

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH MONTH DAY MARY CHRISTINE McSTEEN VYE KAISER YEAR 1996 22 KAISER Jan. CHRISTINE 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign 6. AGE (In yrs, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) DAYS HOURS 1 M 2 W F 082-09-4241 YRS. September 17, 19 13 New Jersey 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Salisbury Nursing & Rehab Center WICOMICO Salisbury, Md. 10c CITY TOWN OR LOCATION 10b. COUNTY 10e STATE Wicomico Salisbury Maryland 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 1313 Spruell Dr. 2 18 04 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 MARITAL STATUS 14. RACE — American Indian, Black, White, atc. t Never Married 2 Merried t YES 2X NO Specify: Specify 3 Widowed 4 N Divorced White 15. DECEDENT'S EDUCATION seelly only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (So Elementary/Secondary (0-12) College (1-4 or 5+) 12 4+ Social Security Administration 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) McSteen Grace Lambdin Joseph 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 1313 Spruell Dr., Salisbury, MD 21801 Mia Christine Vye 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Springhill Memory Gardens Hebron, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 (hommons lance 23. PART i. Enter the diseases, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS 1 YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: t | Inpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 X NO ng Home 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 1 - CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

28e. PLACE OF INJURY - At home, ferm, street, factory, office

INJURY

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and menner as stated

29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 9

1 YES 2 NO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

William RobiNS D 1104 HEALTHWAY DR., SALISBURY, MD. 31. DATE FILED (Month, Day, Year)

JAN 26 1996

Jalia Davidson Randell

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 96

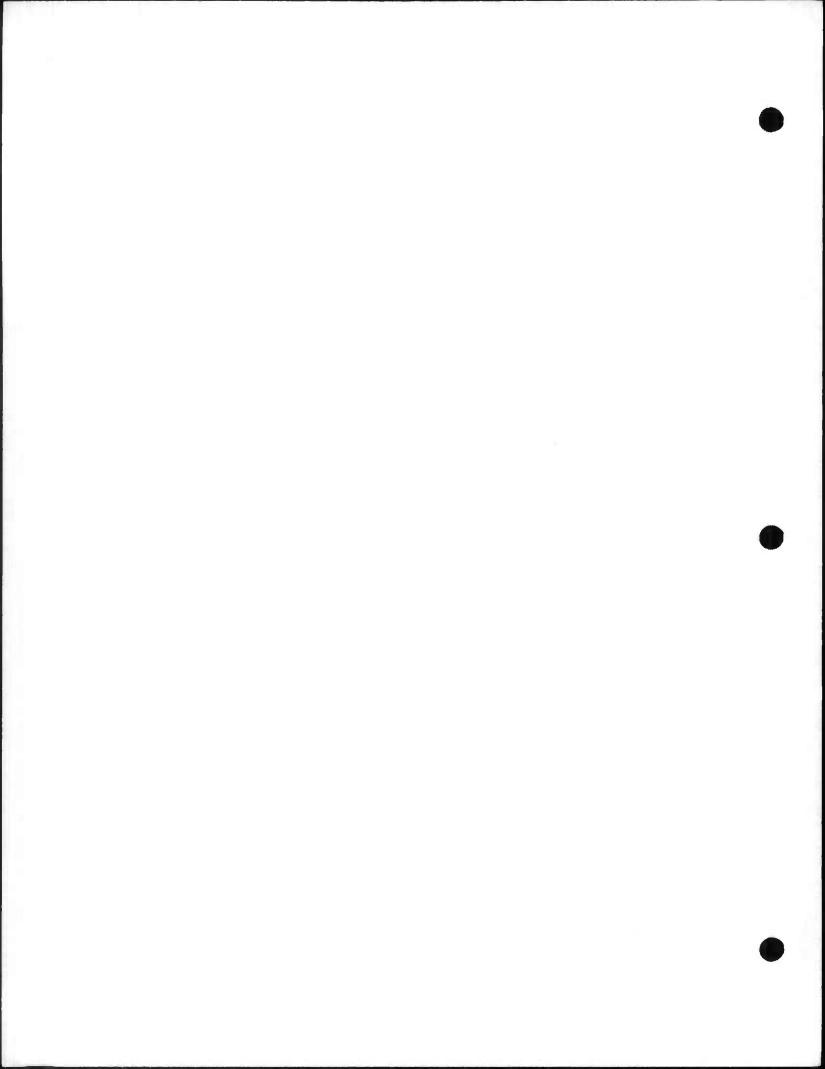
| DENNIS J. December Name First, Medical Labor DENNIS J. KERTESZ J. A. Schip Town, or Losseland Death As. Schip Town, or Lo | | | | | | | Certificat | e of | Death | | Reg. No. | | 00.0 | | | | |
|--|--|---------|---------|--|--|--------------------------------|---------------------------------------|----------------|-----------------------------|---------------------------------|-------------------------------|------------|--|--|--|--|--|
| SHADY GROVE HOSPITAL Showed Soundly Amenian C. Substance of Control of Contr | Dh | i a i a | | 1. Decedent's Name (First, Middla, L | | | | | | 2. Date of De | ath | Voor | 3. Time of Death | | | | |
| SHADY GROVE MOSPITAL South South Year by Name Control Contr | | • | | DENNIS | J. | KE: | RTESZ | | | JÄN. | 25, 19 | 9'6" | 3:00 PM | | | | |
| Secretary Secr | Ex | amin | er | 4a. Facility Name (If not institution, g | ive street end number) | | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | | | | |
| The part of the pa | | | | | | | Milada | 4 7 | | | | | | | | | |
| The control of the co | | | | | | | Months | | | . (Month, De | y, Year) | | pleca (State or Foreign intry) | | | | |
| The state of the part of the p | | ctor | | | | 91 | | | | Jan. 5 | , 1905 | Hung | ary | | | | |
| Committee Comm | Mend | 16 | | | | 10c. City, Town | or Location | | | | | | 10d. Inside City Limits | | | | |
| Security Company Com | Me J | E E | to | Maryland Mont | tromers | Silvo | r Caria | . ~ | | | | | 1√2 Yas 2□No | | | | |
| Security Company Com | 2 B | 905 | irec | | egomery | DITAG | | | | 10g. Citizan of What Country? | | | ntry? | | | | |
| Committee Comm | ₩ K | 칕 | | 1316 Fenwick Lane | #715 | | | 200 | 10 | | II C A | | | | | | |
| Security Company Com | deat | 5 | ner | | | rer In U,S. | 13. Was Deced | dent of | Hispanic Origin? (S | Specify Yas or No | - 14. Re | | | | | | |
| Committee Comm | o effar | Ē | | 1 Never Married 2 Married | 1 Yas 2 No | | | | | to Hican, etc.) | | | etc. | | | | |
| Security Company Com | ours raf. | 8 | | 3 € Widowed 4 Divorced | Year or Datas: U | nknown | 1 165 | ZALI NO | эреспу. | | Specii | | e | | | | |
| The DO NOT use refreed Chemistry | 72 h | 8 | etec | 15. Decedent's I (Specify only highest g | Education reda completed) | 16a. D | ecedent's Usua Give kind of wor | l Occu | pation during most of wo | rking | 16b. Kind of B | usiness/in | idustry | | | | |
| State Stat | N # . 5 | 됩 | Idu | Eiementary/Secondary (0-12) | | } | | sa retire | ed) | | | | | | | | |
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| 20. Manno of Disposition (Parent) 20. Manno of Disposition (Parent) 20. Manno of Disposition (Parent) 20. Manno of Disposition (Parent) 20. Manno of Disposition (Parent) 20. Manno of Disposition (Parent) 21. Signature of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno of Manno Same (Parent) 22. Manno | | | | | | | | | | | | | | | | | |
| Disputed 2 (December 1/31/96 Alexandria, Virgin 1/31 | | the | ŀ | | 52 | 20b. Placa of D | isposition (Nen | ne of | T | | | | | | | | |
| Physician Medical Examiner Physician Inc. Solutiversity Blvd., W. Sil.spr., MD 20901 Physician Medical Examiner Physician Inc. Solutiversity Blvd., W. Sil.spr., MD 20901 Physician Medical Examiner Immediate Cause (Final reculting in death) Immediate Cause (Final reculting in death) Due to (or as a consequence of): Sequentially list conditions cause in finity Tresulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions cause in finity resulting in death) Perf II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause in line and an incidence in the cause in line and an incidence in line and an in | | 20 | | 1 Burial 2 Cremation 3 | | cametery, | cremetory or o | ther pie | 1 | | | | | | | | |
| Physician Medical Examiner Physician Inc. Solutiversity Blvd., W. Sil.spr., MD 20901 Physician Medical Examiner Physician Inc. Solutiversity Blvd., W. Sil.spr., MD 20901 Physician Medical Examiner Immediate Cause (Final reculting in death) Immediate Cause (Final reculting in death) Due to (or as a consequence of): Sequentially list conditions cause in finity Tresulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions cause in finity resulting in death) Perf II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause in line and an incidence in the cause in line and an incidence in line and an in | Itir Purtue | of a | - | | | Metropo | litan C | rem | atory 1 | /31/96 | Alexand | ria, V | /irginia | | | | |
| 23a Part Enter the disease, or complicated that caused the feath in Do not enter the mode of dying, such as cardiac or respiratory arrest. 29a Part Enter the disease, or complications another or near that the cause of the feath in Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation another interests or condition resulting in disease) Due to (or as a consequence of): | Ba Pem Depa | Suce | | 12/1/1/ | | | | | | Funeral | Home, | Inc. | | | | | |
| Physician // (Actical Examiner) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sequentially list conditions of any investigation of any invest | | | | Dobul C | . I am | deg | 500 Uni | ver | sity Blv | 1. W. S | il.Spr. | | | | | | |
| The deficiency of the second process of the | | | - | shock, or heert feilure. List onl | mplicetions that caused to y one cause on each line | nerdeath. Do not | enter the mod | e of dy | ng, such as cardia | c or raspiratory a | rrest, | | Intarval Between | | | | |
| Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a | | _ | | Immediate Cause /Final | 4.00 | 1 - 10 | (TIN. | | | | | - | Criset and Death | | | | |
| Sequentielly list conditions, and contributed to the cause of the conditions of any leading to immediate cause. Enter Underlying cause given in Part I. Due to (or as a consequence of): | The second second | | | disease or condition | a. /WULT | the 1 | MINK | 5 | | | | | | | | | |
| Cause (Disease or Influty The part I. Cause (Disease or Influty The part II. Cause (Disease or Influty The part II. Cause (Disease or Influty The part III. | | | ē | | D | ue to (or es e co | nsequence of): | | | | | 1 | | | | | |
| Cause (Disease or Influty The part I. Cause (Disease or Influty The part II. Cause (Disease or Influty The part II. Cause (Disease or Influty The part III. | petn p | ansit | 直 | Commented to the control and the | b | un to for an a cor | , , , , , , , , , , , , , , , , , , , | - | | | | | | | | | |
| Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a | O, exec | rial tr | X | if any, leeding to Immediata causa. Enter Underlying | <i>D</i> | ue to (o) as a cor | isequence or). | | | | | 1 | | | | | |
| Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 | 176 ite be | ng e | Ca | Cause (Disease or Injury that inflated events Due to (or as a consequence of): | | | | | | | | | | | | | |
| Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 | 68 rtifica | as t | 260 | resulting in deeth) Last | | | | | | | i | | | | | | |
| The state of the s | SOX th ce | L USB | an/ | | d | | | | | | | | | | | | |
| State 24a. Was en eutopsy performed? 24b. Were autopsy aveilable prior completion of death? 24c. Place of Death (Check only one) 25d. Death (Injury at Month, Dey Year) 25d. Death (Injury at Month, Dey Year) 25d. Death (Injury at Month, Dey Year) 25d. Death (Injury at Month) 25d. Death | 0 0 4 | ě | SICI | Pert II. Other significant conditions | contributing to death but | not resulting In th | ne underlying c | ause gi | ven in Part i. | 23b. Dld | tobacco use co | ntribute t | o the cause of death? | | | | |
| 248. Was an eutopsy available prior completion of of death? 248. Was asserted to medical axeminer? 1 | | etact | P P | | | | | | | 10 | Yes 2 No | 3 ☐ Pro | bebly 4 Unknow | | | | |
| 25. Was case referred to medical axeminer? 26. Place of Death (Check only one) 27. Manner of Death 28. Det of Injury 28. De | S, as the | 8 . | | | | | | | | | | T | | | | | |
| 25. Was case referred to medical axeminer? 26. Place of Death (Check only one) 27. Manner of Death 28. Det of Injury 28. De | Orc inpering | DIDOL . | jed | | | | | | | | | av | ere autopsy findings eilabie prior to | | | | |
| 25. Was case referred to medical axeminer? No No No No No No | O × S | 20 | od l | | | | | | | | | of | death? | | | | |
| 25. Was case referred to medical axeminer? 26. Place of Death (Check only one) 27. Manner of Death 1 Naturel 1 Naturel 28. Dete of Injury 19 North Death 1 Naturel 28. Dete of Injury 19 North Death 1 Naturel 28. Dete of Injury 19 North Death 1 Naturel 28. Dete of Injury 19 North Death 1 Naturel 28. Dete of Injury 19 North Death 1 Naturel 28. Dete of Injury 19 North Death 1 Naturel 28. Dete of Injury 19 North Death 1 N | = = = | pag | 000 | | | | | | | 1)(| Yes 2□ No | 1 | Yes 2□ No | | | | |
| Table Tabl | /ita | ŏ | | | | | | | 26. Place of De | ath (Check only o | one) | (| | | | | |
| State Stat | hysic of his co | | 0 | | Hospitai: 1 Inpetient | 2 X ER/Outpo | atient 3 DO | A OI | her: 4 Nursing I | lome 5 Resid | dence 8 🗆 Oth | ner (Speci | fy) | | | | |
| 29a. Certifier (Check only one) 29b. Signature and dite of certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 29b. Signature and title of certifier (Check only one) 29c. License numbar (D. C. M. E. JAN. 26, 1996) 30. Neme and eddress of person who completed datase of death (htm /23a) (Type, Print) 11 Penn Street, Baltimore, Maryland 212. 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | | neus | 5 | And the second s | 28a. Dete of Injury (Month, Dey) | | ne of 2 | 8c. Inju Wo | ry at rk? | | | | 24 8416 | | | | |
| 29a. Certifier (Check only one) 29b. Signature and dite of certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 29b. Signature and title of certifier (Check only one) 29c. License numbar (D. C. M. E. JAN. 26, 1996) 30. Neme and eddress of person who completed datase of death (htm /23a) (Type, Print) 11 Penn Street, Baltimore, Maryland 212. 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | SiO Seath Seath | 196 | cati | 2 Accident investigation | 1-07 12 | 132 | O M | 1 [| Yes 2 No | | | | | | | | |
| 29a. Certifier (Check only one) 29b. Signature and dite of certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 29b. Signature and title of certifier (Check only one) 29c. License numbar (D. C. M. E. JAN. 26, 1996) 30. Neme and eddress of person who completed datase of death (htm /23a) (Type, Print) 11 Penn Street, Baltimore, Maryland 212. 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | Y At At Office of the column o | À L | | determine | 289. Placa of Injury | · - At home, farm (Specify) | , street, fectory | , office | | 28f. Location (S City or Tox | Street end Numi vn, Steta) | ber or Run | al Route Number | | | | |
| 30. Neme and eddress of person who completed datase of death (horr/23s) (Type, Print) MACO State 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | I sele | B (| | | | - 1 | , | | | | | 202D | ROCKVILLE | | | | |
| 30. Neme and eddress of person who completed disease of death (thorn/23a) (Type, Print) MACO State 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | Hosp Fund | yek : | ICa | (Check only 2 Medical Exa | minar: On the basis of e | kaminetion and/o | | | | | | | | | | | |
| 30. Neme and eddress of person who completed disease of death (thorn/23a) (Type, Print) MACO State 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | thin | ě : | Š - | - A | end manner state | 1 | 290 | Licen | se numbar | | 29d Date signe | d (Month | Day Year) | | | | |
| 30. Name and address of person who completed datase of death (turn /23a) (Type, Print) MACO 111 Penn Street, Baltimore, Maryland 212 State 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | 도 골 다 | 8 | | I WILLIAM | D (1/0 | 5 | A | | | | | | | | | | |
| State MACO F GOLV JV MM11 Penn Street, Baltimore, Maryland 212 State 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | | | - | 7 | pu | 4/1 | | | | | | , | | | | | |
| State 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature | | | | | LIFE TV A | 1 100 | | +~~ | ot Dal | timoro | M | land | 1 21201 | | | | |
| Oldic | | Stat | | | 32. Registrar | - | enn 3 | CTE | ec, Ddl | гтшоте | , Mary | Tallo | 1 41401 | | | | |
| SAIN SI 1990 AMA DIMENSION AND SINCE | Re | | • | JAN 31 | | | artall | | | | | | | | | | |

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a the second of

| BALTIMORE, MARYLAND 21215-0020 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |
|--|---|
| | within 24 hours after death. Page |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | requires that the death certificate be executed |
| DIVISION OF VITAL | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law |

| _ | 1 - STATE REGISTRAR | SIAIE UF MANT | LAND / DEPARTME CERTIFICA | TE OF DEATH | MENIAL HYGIENE REG. NO. | | | | | |
|------------------|--|---------------------------|------------------------------|--|--|------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | ~ JOSEPH | KNAGO | 2 | 2. DATE OF DEATH DAY | YEAR S | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 577-28-3358 | 5. SEX | 7 2 YRS. WONTH | DER 1 YEAR IF UNDER 24 HRS 6 DAYS HOURS MIN | 7. DATE OF BIRTH (Month, Day, Year) May 3, 1923 | 8. BIRTI Cour | THPLACE (State or Fore stry) SCONSIN | | | |
| стов | 9a. FACILITY NAME (If not institution, give 3806 Palmira Land RESIDENCE OF DECEMENT | | | ty, town on Location of lver Spring | DEATH | Sc. COUNTY OF | | | | |
| AL DIREC | 10e. STATE 10b. COUN | ntgomery | | ver Spring | | IA- CITIZEN OF | 10d. INSIDE CITY LIMITS? 1 YES 2 NOW WHAT COUNTRY? | | | |
| FUNERA | 3806 Palmira Lai | 12. WAS DECEDENT EVER | | 20906 3. WAS DECEMBENT OF HIS | PANIC ORIGIN? (Specify Yes o | U.S.A | CE American Indian | | | |
| В | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 Q YES | DATES | If yes, specify Cuban, Mex 1 YES 2 NO Spe | oolfy: | Spe | ck, White, atc. city: White | | | |
| PLETED | 15. DECEDENT'S EC (Specify only highest gra- Elementary/Secondary (0-12) | College (1-4 or 5+) | Iffe. Do NOT use retire | ne during most of working 1.) | 16b, KIND OF BUSIN | | | | | |
| E COMPL | 17. FATHER'S NAME (First, Middle, Last) Simon John Knagg | 4+ 2s | Liectroni | | Private NAME (First, Middle, Maiden Su Monarcki | | `V | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) Vincent L. Knage | | | SS (Street and Number or Run | Monarski al Route Number, City or Town. | | nd 20070 | | | |
| 7 | 20a. METHOD OF DISPOSITION 1 Disposition 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 2/2/96 Suitland, Maryland | | | | | | | | | |
| | 11. SIGNATURE OF FUNERAL SERVICE L | | | 2. NAME AND ADDRESS OF Francis J. C | | al Home | , Inc. | | | |
| | 23. PART I. Engir the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | Sequentially list conditione, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | ė | A CONSEQUENCE OF): | | | | | | | |
| AL | PART II. Other algnificent condition | ona contributing to deeth | but not resulting in the | underlying ceuse given | In Part I. 24s. WAS AN AU PERFORMI 1 YES 2 | ED? | b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMPLER? MORPITAL: | | | | | | | | | |
| YSI | YES 2 NO | HOSPITAL: | | ER: ursing Home 5 Residence | e 6 C Other (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATH Netural 5 Pending 2 Accident Investigation | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DEŞCRIBE HOW INJ | | | | | |
| ETED | 3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, term, etreet, factory, office building, etc. (Specify) 28e. CERTIFIED 28e. CERTIFIED | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner se stated. | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIF | Samber | - ~ | 29c. LICENSE N | SSC 2 | Ped. DATE SIGNE | 28 9 | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DE | | 18 W 15 | | etter | oder N | | | |



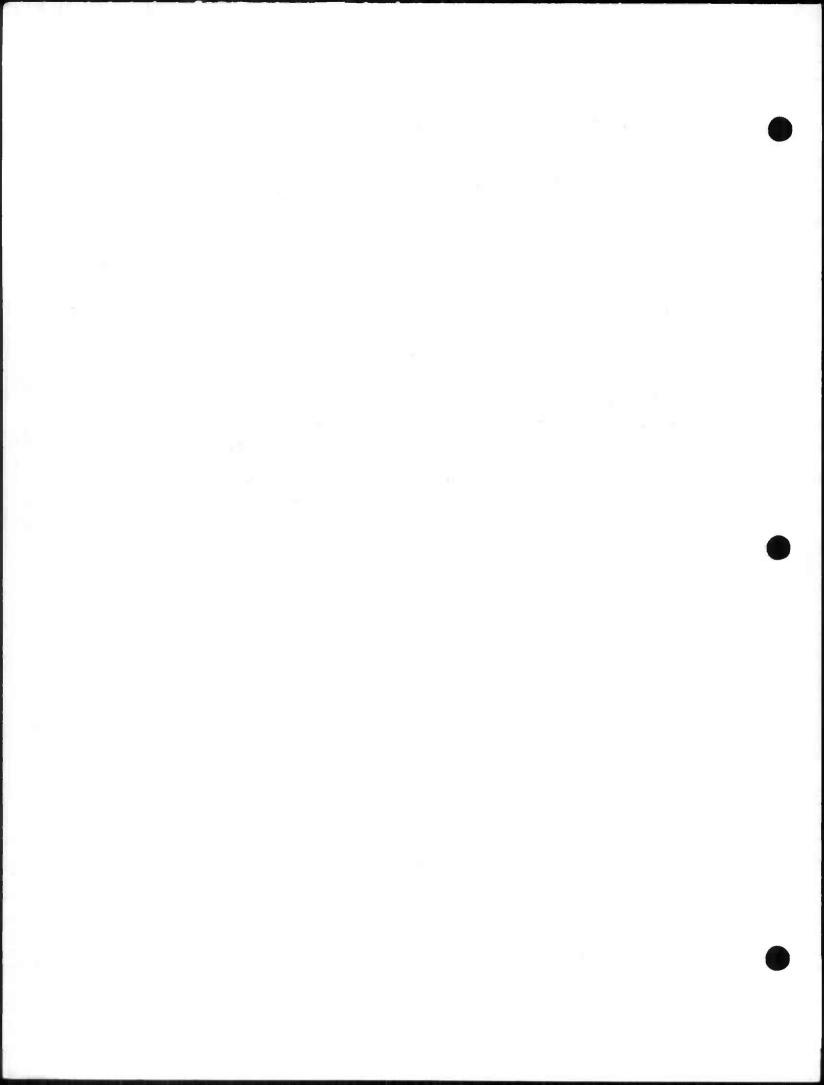
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|--|
|--|---|--|--|

| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | | | | ITAL HYGIENI REG. NO. | E | | |
|------------------|--|--|--|--|---------------------|--|--|-------------------|--------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) HOWARD | W. | KING | - | | | DATE OF DEATH DA | 1996 | YEAR | 5:33 P M |
| | Committee of the commit | | | IF UNDER 1 YEAR | IF UNDER 24 | HRS. 7. E | DATE OF BIRTH Month, Day, Year) | | | CE (State or Foreign |
| | | 1 XM 2 □ F 72 | YRS. | IONTHS DAYS | | S | EPT. 1,1 | | VIRGI | |
| 2 | 9a. FACILITY NAME (If not institution, give stre SHADY GROVE ADVEN | et and number) NTIST HOSPIT <i>F</i> | NL ' | ROC | VILLE | OF DEATN | | 9c. COUNT MONT | OF DEATH | Y |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | |
| DIRECTOR | | GOMERY | | THERSBU | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | | uni. | | ZIP CODE | | 1 ☐ YES 2. NO 10g. CITIZEN OF WHAT COUNTRY? | | | |
| FUNERAL | 939 CLOPPER ROAD | | 1-4 | | | 2087 | | UNITE | D STA | TES |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced | U.S. ARMED 2 NO ES WW II | If yes, sp | ENDENT OF Notice of the Cuben, No. 2 NO. | laxican, Pu | RIGIN? (Specify Yes arto Rican, etc.) | or No— | Black, Wh | American Indian, ilta, atc. | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of | aTION ompleted) | 16a. DECEDENT'S U (Give kind of wo | rk done during mo | ON st of working | | 16b. KIND OF BUS | INESS/INDU | STRY | |
| PLE | Elementary/Secondary (0-12) | CARPENT | | | CONST | RUCTI | ON | | | |
| NO. | 17. FATNER'S NAME (First, Middle, Last) | | | | 18. MOTHER | 'S NAME (| First, Middle, Malden | | OIL | |
| BE (| JOHN H. KING | | | | | GGIE | BRYA | | | |
| ٩ | 19a. INFORMANT'S NAME (Type/Print) MAY E. KING WI | [FE | | OPPER F | | | Number, City or Town | | | 20878 |
| | 20a_METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 20b_PLACE AND DATE OF DISPOSITION/Name of Compating, or other place! 20b_PLACE AND DATE 20c_LOCATION — City or Town, State 2/2/96 FREDERICK, MARYLAND | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | 1 / | 22. NAME AI | D ADDRESS | OF FACILIT | | | | |
| | Murief & | Dark | w | | | | AYTONSVI | | | |
| | 23. PART I. Enter the diseases, or co ahock, or heart failure. Li | mplications that caused ist only one cause on each | the desth. Do no ch line. | 1 enter the mo | de of dying | , auch aa | cardiac or respin | ratory arres | nt, | Approximate Interval Between Onset and Death |
| | disease or condition resulting in death) a. Cerviar area | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| NO | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSTOURNEE OF): UN MANY ORDERS OF THE TOP O | | | | | | | | | |
| CAT | cause. Entar UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | |
| | PART II. Other significant conditions | contributing to death bu | t not reculting in | the underlyin | - cause clu | a la Bort | I. 24s. WAS AN | AUTOROV | Tan wee | of Himmony entertion |
| ICAL | Caneer | continuently to usatti bu | t not resulting in | trie uridanym | J cause give | on in Pari | PERFOR | MED? | CON | RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION DF CAUSE |
| MED | | | | | | | 1 1 123 2 | Thun | | DEATH? YES 2 NO |
| AN: | DID TOBACCO USE CONTR | | | NO [| UNCER | TAIN E | | | | |
| SICI/ | | HOSPITAL: 1 topetient 2 ER/Outpet | | OTHER: | | | 00-40-41 | | | |
| PHYSICIAN: MEDIC | 27. MANNED OF DEATN | 26s. DATE OF INJURY (Month, Day, Year) | 28b. TIME | | | | . DESCRIBE HOW IF | JURY OCCU | RED | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 🗆 | rES 2 N | | | | | |
| TED | 3 Suicide 6 Could not be 4 Homicide detarmined | 26s. PLACE OF INJURY - building, atc. (Specif | — At nome, term, etc | eet, factory, offic | | 261 | LOCATION (Street a City or Town, State) | nd Number o | r Rurei Route | Number, |
| COMPLET | | IAN: To the best of my knowle : On the basis of examination | | | | | | | | d manner as stated. |
| BE CC | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENS | | | | | nth, Day, Year) | |
| TO B | pymen | m0 | - | | 754 | 97 | | an | my 3 | 0,1996 |
| | 30. NAME AND ADDRESS OF PERSON WHD | COMPLETED CAUSE OF DEAT | | 24 | | Rocu | cielle. N | 10. | 3 | |
| | 31. DATE FILED (Month, Day, Year)— FEB 01 199 | 6 Julia Stude | The state of the s | | | | | | | |
| | FEB 01 199 | DI Java avende | ex variable | | | | | | | DHMH-16 Rev 1/89 |





BALTIMORE, MARYLAND 21215-0020

burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| eath | atten | Ttal H | y, 0f |
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| that | d pe | Ith an | any |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| STATE OF MAR | YLAND / DEPAI | RTMENT OF | HEALTH AND | MENTAL | HYGIEN |
|--------------|---------------|-----------|-------------------|--------|----------|
| | CERTIF | ICATE O | FDEATH | | REG. NO. |

| | FOR STATE OF MARYLAND 1 - STATE REGISTRAR | / DEPARTM | | | ENTAL HYGIEN | E | | | | |
|--------------------|--|--|--|----------------------|------------------------------|-----------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH DA | | 3. TIME OF DEATN | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In VIS. | E | | | JAN 29 | | 2:37 P M | | | |
| | 335-01-3113 1□M2⊠F 88 | 1 M 2 M F 88 YRS. MONTHS DAYS HOURS MIN. (Month, May | | | | .907 Ne | ew York | | | |
| E. | ee. FACILITY NAME (# not institution, give etreet end number) Washington Adventist Hospital | 96. | Tako | R LOCATION OF DEAT | Н | 9c. COUNTY OF | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | Montgo | | | | |
| IR. | 10e. STATE 10b. COUNTY MD • P • G • | | WN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? 1 XXYES 2 NO | | | |
| | 10e. STREET AND NUMBER | | - | ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | |
| FUNERAL | 5805 42nd. Ave. Apt. 422 | | | 20781 | | U.S.A | Α. | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | IED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No. 14. RACE - America | | | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | DECEDENT'S USU (Give kind of work | AL OCCUPATIO | N | 16b. KIND OF BUS | BINESS/INDUSTRY | 111111111111111111111111111111111111111 | | | |
| LET | Elementary/Secondary (0-12) College (1-4 or 5+) | life. Do NOT use ret | (red.) | t or working | | | | | | |
| COMPLETED | 12 17. FATNER'S NAME (First, Middle, Last) | Homema | ker | 40. 1407115010 11411 | Home | | | | | |
| | Luigi Panateri | | | Maria | | Rizzo | | | | |
| BE (| | 19b. MAILIND ADD | PRESS (Street a | | ute Number, City or Town | | | | | |
| 2 | Robert L. Kane | 5337 H | ighwhe | els Crt. | Columbia, | MD. 210 | 044 | | | |
| | 20c. METNOD OF DISPOSITION 1 K Buriel 2 Cremetton 3 Removal from State 4 Donetton 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory profiner place) Gate Of Heaven Cemetery 2/2 Silver Spring, MD. | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | O ADDRESS OF FACIL | | | Co. Inc. MD. 20737 | | | |
| | 23. PART I. Enter the diseases, or complications that caused the | | | | | | Approximata | | | |
| | ahock, or heart failure. List only one ceuse on each if | | 1 0 | 0: | 0.0 | | Interval Batween Onset and Death | | | |
| | disease or condition resulting in death) | | AR- | 721-4 | DISK | ASE | 5 yr | | | |
| N | DUE TO (OR AS A CONSEDUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): | | | | | | | | | |
| ATIC | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| FIC | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONS | | | | | | 1 week | | | |
| CERTIFICATION | resulting in death) LAST | - FA | ILIU F | 25 | | | 1 Wee L | | | |
| PHYSICIAN: MEDICAL | PERICHERAL VASC | | | | | RMED? | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| ME | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE | EATU VEC | | UNCERTAIN | M | | 1 TES 2 ND | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL 26. PL | LACE OF DEATH (| | OINCERIAIN | 400 | | | | | |
| SIC | EXAMINER? 1 YES 2 NO 1 Postient 2 ER/Outpatient | | THER: Nursing Nom | e 5 🗆 Residence 8 | ☐ Other (Specify) | | | | | |
| PHY | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | | URY AT : | 28d. DESCRIBE HOW I | NJURY OCCURED | | | | |
| BY | 1 Pending 2 Accident Investigation | | M 1 🗆 1 | | | | | | | |
| | 3 Suicide 8 Could not be determined 28. PLACE DF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28. PLACE DF INJURY — At home, farm, street, factory, office City or Town, State) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Do the best of my knowledge, | | | | | | o(e) and menner as stated. | | | |
| | 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIDNED (Month, Day, Yegr) | | | | | | | | | |
| TO BE | VP 874 VITTE | ind ! | ys. | 2198 | -97 | ▶ 1,2 | 996 | | | |
| - | | ANOVE | RP | ARKUH | Y GAR | ENBE | IT MO2 - 77 | | | |
| | 31. DATE FILED (MONT), Day, Year) | solall. | | | • | | | | | |

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3. TIME OF DEATH

10d. INSIDE CITY

1 YES 2 NO

White

20903

Approximate Interval Bety

AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 | YES 2 | NO

Onset and Death

2 DAYS

PM

9:45

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train | eath |
| ENDI | DR: A | fer d |
| R AT | RECTI | urs ai |
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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)

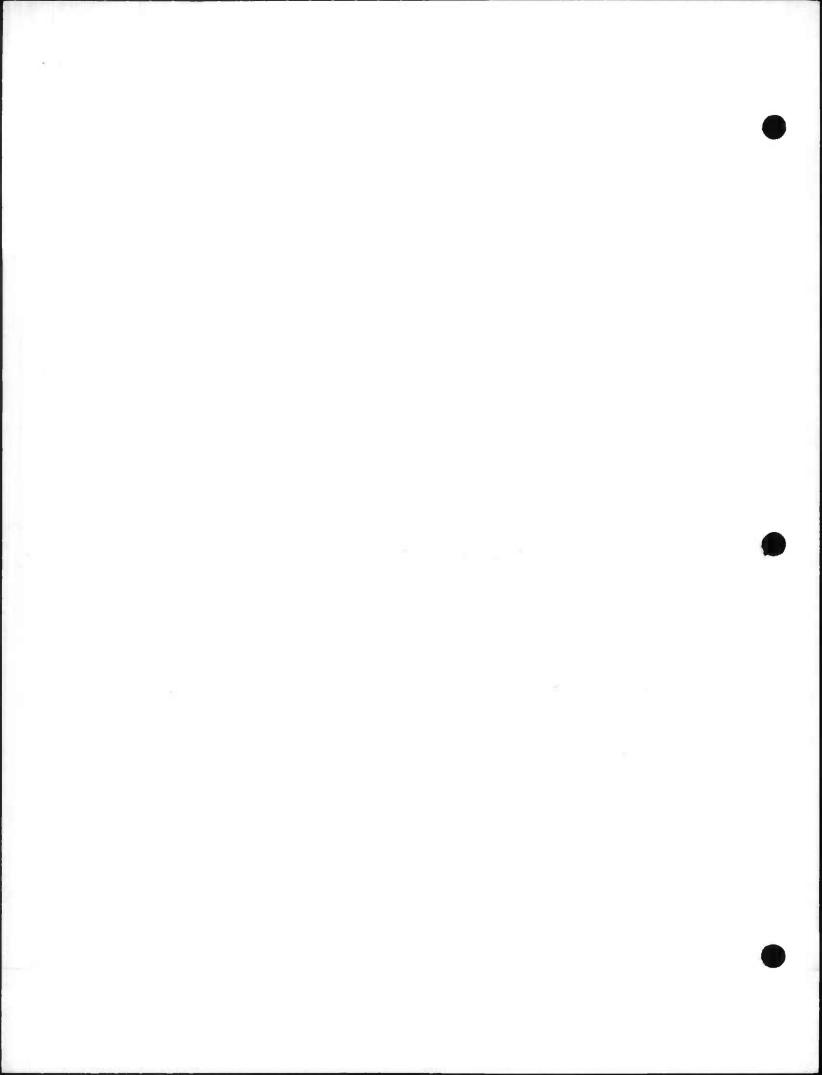
JAN 30 1996

2. DATE OF DEATH January 26,1996 YEAR Agnes Martina Keener 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Morith, Day, Year)
Dec. 12,1905 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 SF 90 578-03-7949 Maryland t. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR Hill Haven Nursing Home Adelphi Prince Georges RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9409 New Hampshire Avenue 20903 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 X NO 1 Never Married 2 Married 1 YES 2 X NO Specify: B 3 🔀 Widowed 4 🗌 Divorced BE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Operator Communications be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) George Totten, Sr. Agnes Martina Waple 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 Eulah E. Rosen 9409 New Hampshire Ave., Silver Spring, MD 20s. METHOD OF DISPOSITION
1 CBurlel 2 Cremation 3 Re DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Maryland Veterans Cemetery 1/31/96 Cheltenham, MD □ Donation 8 □ Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901 Enter the diseases, or complications that caused the de-shock, or heart failure. List only one cause on each line. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, IMMEDIATE CAUSE (Final 計 disease or condition NEUMONIA TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires with the Stringle by the attending physician and completely TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremat iMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS HEART DISEASE 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA rsing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28c, INJURY AT WORK? 28s. DATE OF INJURY (Month, Day, Year) 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending Investigation BY 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide determined 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, dete and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) D31563 BE MIN 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles M. Benner M.D. 11251 Lockwood Drive, Silver Spring, MD

32. REGISTRAR'S SIGNATURE

whi Devolus Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**



6 may be retained by the hospital or attending physician. ector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL BECORDS P.O. BOX 68760

| 2 | Page | dire | 101 |
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| DALIIM | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the burs after death. Page | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dire be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner is |
| ٥ | urs after | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | edical |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | F DEATH | | AY YE | | | | |
|-----------------------|--|--|--|---|--|--|---------------------------------------|---|--|--|--|
| | ROBERT (| 5. SEX 8. A | | LONG | | 01 2: | | | | | |
| | 219-07-6699 | -6699 1 XM 2 □ F 76 YRS. MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 05-15-19 | 9 M | ARYLAND | | | | | |
| TOR | 99. FACILITY NAME (If not institution, give PENINSULA REGIONAL RESIDENCE OF DECEDENT | | CENTER | SALIS | N OR LOCATION OF D | DEATH | WICOM | | | | |
| DIRECTOR | MARYLAND SOME | ERSET | 10c. CITY | | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | | | | | |
| FUNERAL | 100. STREET AND NUMBER 8996 CRISFIELD | HIGHWAY, PO | | 10g. CITIZEN OF | | | | | | | |
| TO BE COMPLETED BY FU | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 X Y IF YES, GIVE WAR O | ER IN U.S. ARMED ES 2 NO R DATES | NIC ORIGIN? (Specify Yeen, Puerto Rican, etc.) | RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | |
| | WILLIAM B. LONG ETHEL MILES | | | | | | | | | | |
| | DANIEL M. LONG 11628 SOMERSET AVENUE, PRINCESS ANNE, MD | | | | | | | | | | |
| | 20e.METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Ren 4 Donetion 5 Other (Specify) | | 206. PLACE AND DATE OF | | | | NCESS / | ANNE, MD. | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | Henn | 1 | HINN 1167 | ANO ADDRESS OF F MAN FUNER 73 SOMERS | AL HOME ET AVE. PI | RINCESS | ANNE MD. 218 | | | |
| | PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximation interval B Onset and Conset a | | | | | | | | | | |
| ERTIFICATION | Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | | |
| EDICAL C | PART II. Other significant condition HYPERTENSIVE DIA | | h but not resulting l | n the underly | ing cause given in | PERFO | RMEO? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | PERIPHERAL VASCU | | IVE DISEAS | Ξ | | 1 TYES | Z M MO | OF DEATH? | | | |
| Σ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 40. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: | | | | | | | | | | |
| SICIAN: M | | 1X Inpatient 2 ER/ | | | | Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED FELL DOWN STAIRS | | | | | |
| BY PHYSICIAN: M | EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident investigation | 28a. DATE OF INJU 28a. DATE OF INJU (Month, Day, Ye. 01-21-96 28a. PLACE OF INJ | URY — At home, ferm, s | JRY M 1 | WORK? YES 2 X NO | | | | | | |
| ED BY PHYSICIAN: M | EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 5 Could not be determined | 28a. DATE OF INJU 28a. DATE OF INJU (MONTH, Day, Ye O1 - 21 - 96 28a. PLACE OF INJ building, etc. (HOME-899 | URY — At home, ferm, s Specify) 6 CRISFIEI | IT I I I I I I I I I I I I I I I I I I | YES 2 X NO | 28f. LOCATION (Street City or Town, Stefe WESTOVER, | end Number or R) MD | | | | |
| D BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 5 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS | 28a. DATE OF INJU (Month, Day, Va. 01 - 21 - 96. 28a. PLACE OF INJU building, etc. (HOME - 899 BICIAN: To the best of my k ER: On the basie of examin | URY — At home, ferm, s Specify) 16 CRISFIEI nowledge, death occurre | M 1 [Treet, factory, of JD HIGH d at the time, d | YES 2 X NO Mice WAY ste end place, and du | 28f. LOCATION (Street City or Town, Stele WESTOVER) e to the cause(s) and mae time, date and place, as | end Number or R) MD inner as stated. | | | | |

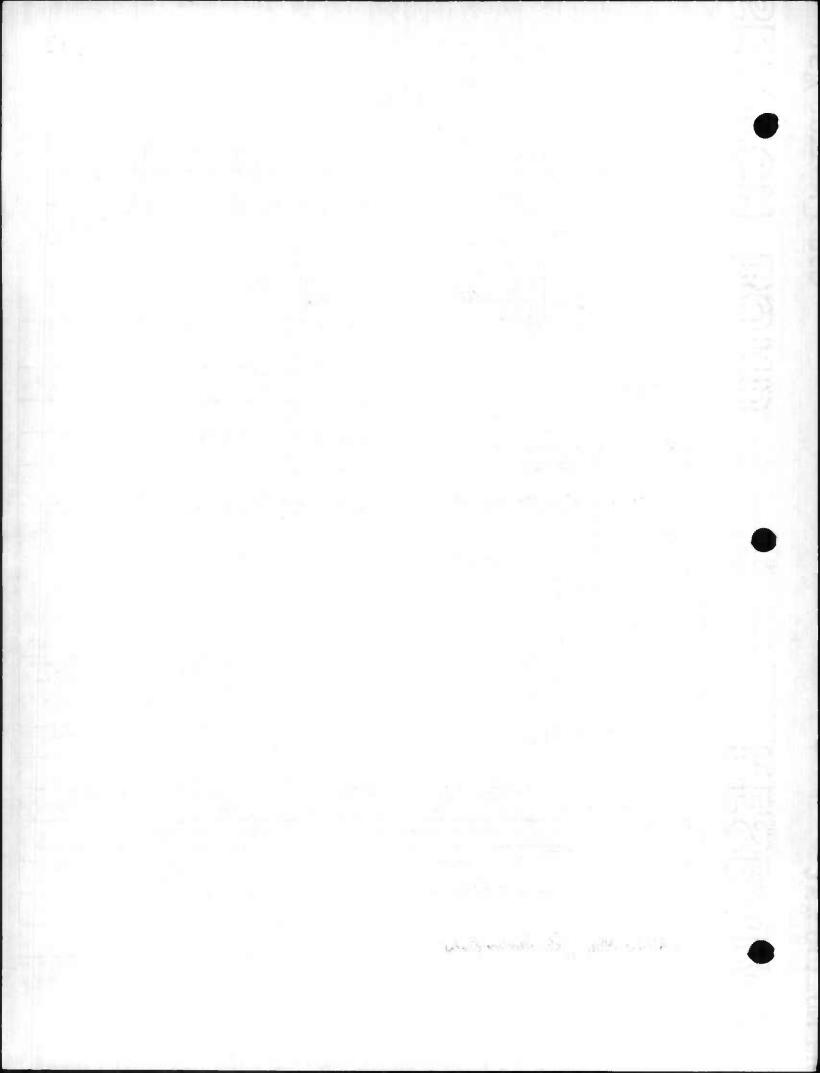
SALISBURY,

MD 21801

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (%po. Print)

BULKELEY

Jelin Surden Redall



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| | Pages | | |
| | or, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, | | |
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| s that | ned by | ofth and | AUN |
| SICIAN: The law requires that the death cer | certificate has been signed by the attendi | ith the State Dept. of Health and Mental Hygi- | chows |
| he law | has b | e Dept. | n 23 |
| JAN: T | rtificate | ne Stati | or ite. |
| PHYSIC | this ce | with th | rked |
| THE HOSPITAL OR ATTENDING PHYSICI | HE FUNERAL DIRECTOR: After this of | filed within 72 hours after death with | PORTANT: if item 28 is marked or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once. |
| ATTE! | RCTOR. | irs after | m 28 |
| TAL OF | M. DIF | 72 hou | H Hat |
| HOSPI | FUNEF | within | TAMT |
| 17 | THE O | filed | IPOR |

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| | FOR 1 - STATE REGISTRAR | STATE OF I | | | TMENT OF ICATE OF | | MENTAL HYGIEN REG. NO | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | MY YEAR | 3. TIME OF DEATN | | | |
| | Anne | | Graeme | | Laws | | | 20, 1996 | | | | |
| | 4. SOCIAL SECURITY NUMBER 224-86-0404 | 5. SEX | 6. AGE (In yrs. la | at birthday) YRS. | F UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 25 | | TNPLACE (State or Foreign intry) MD | | | |
| | Se. FACILITY NAME (If not institution, give a | | | 9b. CITY, TOWN | OR LOCATION OF DE | | 9c. COUNTY OF | | | | | |
| DIRECTOR | Calvert Memorial | Hospita | al | | Princ | e Frederi | ick | Cā | alvert | | | |
| E I | 10+. STATE 10b. COUNTY | , | | 10c. CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY | | | |
| | MD (| Calvert | | | Lush | - | | | 1 YES 2 NO | | | |
| RA | | | | | 1 | of. ZIP CODE | | 24. | F WHAT COUNTRY? | | | |
| W. | 12146 Catalina I | | | | | 20657 | | | S.A. | | | |
| FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDED | T EVER IN U.S. AI | RMED NO | | CENDENT OF HISPAN pecify Cuben, Mexicer | IC ORIGIN? (Specify Yen, Puerto Ricen, atc.) | | ACE — American Indian, ack, White, etc. | | | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE | MAR OR DATES | | | S 2 NO Specify | | Sp | ecity: | | | |
| | 15, DECEDENT'S EDU | CATION | 40.0 | COCOCUTIO | | | 1 | | white | | | |
| I | (Specify only highest grade | completed) | (0 | Give kind of a B. Do NOT us | WORK done during m | ION lost of working | 18b. KIND OF BU | ISINESS/INDUSTRY | | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Cle | | | U.S. P | ostal Se | ervice | | | |
| Ö | 17. FATNER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NAI | ME (First, Middle, Maiden | Surname) | | | | |
| BE (| Ernest | | Van | Vlaa | anderen | Mary | Anne Har | rvman | | | | |
| | 19e, INFORMANT'S NAME (Type/Print) | | | | | and Number or Rural F | Toute Number, City or Tou | | | | | |
| 5 | Mary Van Vlaande | eren | | 2315 | Nordok | Avenue | Alexandri | a, VA 2 | 22306 | | | |
| | 20e. METNOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Rem | | 20b. PLACE | ANDDATE | OF DISPOSITION (A | lame of | DATE 20c. LC | OCATION — City or | Town, State | | | |
| | 4 Donation S Other (Specify) | Oval from State | Harry Harry | man F | amily C | Cemetery 1 | -24-96 C | ockeysvi | ille, MD | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | gener / | / | | 22. NAME | AND ADDRESS OF FAC | | | | | | |
| | 1/21/ | 11/ | | | Payro | ch Funero | al Home, P | A Orring | rs, MD 20736 | | | |
| | 23. BART I. Enter the diseases, or | compliant lights the | at caused the d | esth. Do i | | | | | Approximate | | | |
| | 23. BART I. Enter the MS ases, or shock, or heart fallure. | List only one ca | use on aach lin | a. | not cintor the in | out of dying, such | . as caraiae or resp | natory arrest, | Interval Between | | | |
| - 10 | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | |
| | resulting in death) | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| O | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| AT | If sny, lesding to immediata csuse. Enter UNDERLYING | 530. | (011101101101 | | . , | | | | | | | |
| 은 | CAUSE (Disesse or Injury that Initisted events | c. DUE TO | OR AS A CONSE | OUENCE O | F): | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | |
| CE | | d. | | | | | | | | | | |
| AL | PART II. Other aignificant condition | a contributing to | death but not | rasulting | In the underlyl | ng causa givan In | Part I. 24s. WAS AN PERFO | | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| SC | | | | | | | 1 _ YES | - | COMPLETION OF CAUSE OF DEATH? | | | |
| Ä | | | | | | | | | 1 YES 2 NO | | | |
| PHYSICIAN: MEDICAL | DID TOBACCO USE CONT | RIBUTE TO CA | AUSE OF DEA | ATH YI | ES NO [| UNCERTAIN | V | | | | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | 28. PLA | CE OF DEA | TN (Check only one | 9) | | | | | | |
| Sic | EXAMINER? 1 ☐ YES 2 ☑ NO | HOSPITAL: | ☐ ER/Outpatient | 3 DOA | OTHER: | me 5 Residence | 8 Other (Specify) | | | | | |
| H | 27. MANNER OF DEATN | 28e. DATE O | F INJURY | 28b, TIM | E OF 28c. If | JURY AT | 28d. DESCRIBE HOW | INJ#RY OCCURED | | | | |
| | 1 Natural 5 Pending | (Month. | Day Year) | IN. | / | YES THE NO. | 1.1 | 10 | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE | OF INJURY - At h | ome, ferm. | 7 - | 7 - 1 | 28f. LOCATION (Street | and Number or Rus | ni Brute Number | | | |
| COMPLETED | 4 Homicide 8 Could not be | building | , etc. (Specify) | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or Town, Stete |) | | | | |
| Щ | 29e. CERTIFIER | | | | | | | | | | | |
| MP | (Check only | | | | | | to the cause(e) end me | | | | | |
| 8 | MEDICAL EXAMINE | H: Un the basis of | exemination end/or | r investigatio | on, in my opinion, | death occured at the | time, date end place, e | nd due to the ceus | e(e) end menner es stated. | | | |
| BE | 295. SIGNATURE AND TITUE OF CENTIFIE | n | | | | 29c. LICENSE NUM | MBER | | IED (Month, Day, Year) | | | |
| TO E | 14/100 | > | | | | 1 D45 | 785 | 1,7 | 23.96 | | | |
| H | 30. NAME AND ADDITION OF PERSON WA | O COMPLETED CAL | JSE OF DEATH (IT | EM 27) (Type | o, Print) | 55 STOA | | CZA | | | | |
| - | HARRY | Kers | Sidie | M | D. | 821-CC | Prooce | US M | 10 20678 | | | |
| | 31. DATE FILED (Month, Day, Year) | 1 1 | AR'S SIGNATURE | 0 | | | | , | | | | |
| | JAN 25 199 | 10 / | a respond | ardall | | | | | | | | |
| | | | | | | | | | | | | |

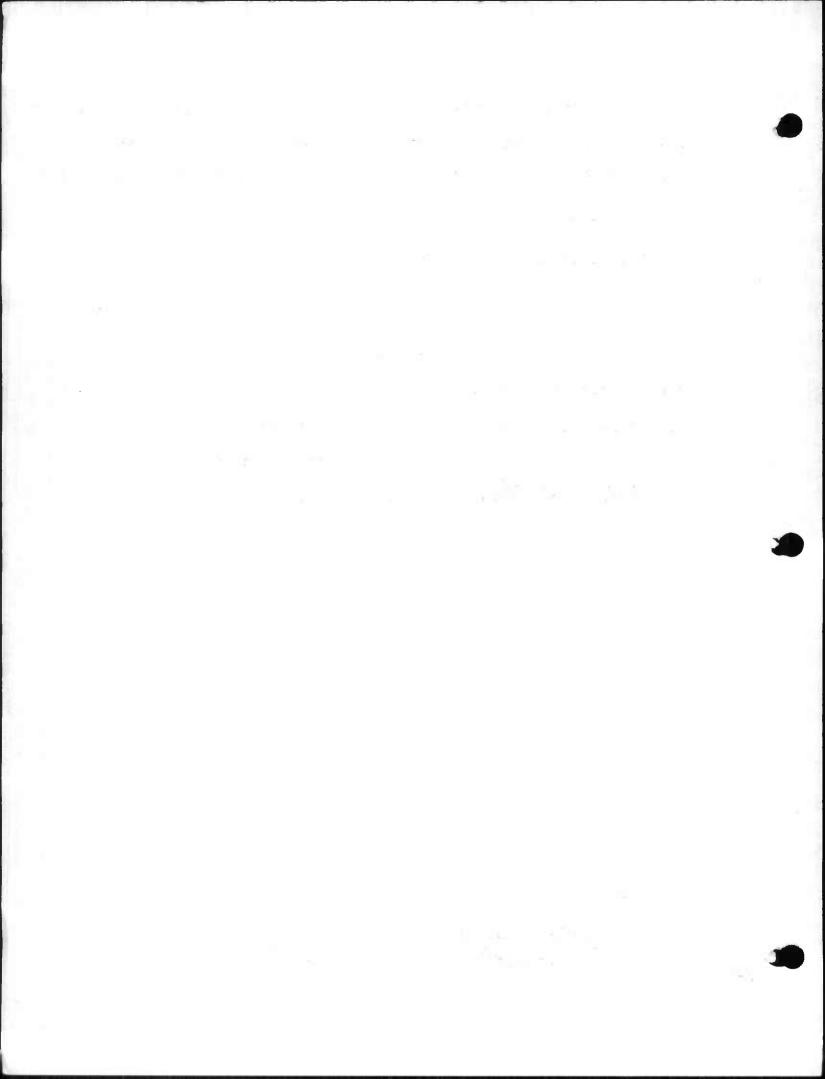
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month CATHRYN MILHADO LYONS 1996 4:30 pm 24 Jan. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 150 East Chesapeake Beach Road Owings Calvert If Under 1 Year If Undar 24 Hrs. 8. Data of Birth Months Daya Houra Min. (Month, Day, Ye 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Daya 1 □ M 2 X F Mar 18, Director 213-38-1540 75 1920 Maryland Usual Rasidence of Decedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mentle itygiene. Important: If item 23 e or 28e-f ahow any intro or and 12 is marked other than "natural", or itema 23e or 28e-f ahow any injury or other traumatic a varit, in a Mendical Example man be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. fosida City Limits Director Calvert 1 ☐ Yas 2 ☒ No Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20736 USA 150 East Chesapeake Beach Road Funeral 12. Was Decedent Ever In U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yaa or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Nevar Married 2 N Married 1 ☐ Yaa 2 ☑ No If Yas, Giva Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) school teacher education 6 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surname) Be Mills Hunter Walters Milhado Helen 10 19a. Informani's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) same as # 10 above H. Arnold Lyons/spouse 20a. Mathod of Disposition 20b. Place of Disposition (Nema of cematary, crematory or other place) Data 20c. Location - City or Town, State 1K Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata All Saints Cemetery Jan 27, 1996 Sunderland, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvica Licensea 22. Nama and Addrass of Facility cli Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the diseese, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrasi, shock, or heart failure. List only one causa on each line. Approximata Interval Between Onset and Death **Physician** /Medical fmmediate Causa (Final ung Cancer disaasa or condition resulting In daath) 0510 Examiner Due to (or as e consaquance of): Examine or Attanding Physician: The lew requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Diseasa or injury that initiated events resulting in daath) Lasl Dua to (or as a consequence of): Box 68760. ettending physician for use as the buria Physician/Medicai Dua to (or as a consequance of): ed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by page 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown Gastrointestina à Pancy topeni 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No certificate 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) 2 1 Yea 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Data of fnjury (Month, Day Year) 27. Mannar of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Affer 5 Pending invasligation 1- Natural death. 1 Tyes 2 TNo 2 Accident after death Director: within 24 hours after dear To the Funeral Director completely filled in by the 6 Could not be detarmined 3 Sulcide 28a. Place of Injury - Al homa, farm, streat, factory, office building, atc. (Specify) 281. Location (Straat and Number or Rural Route Number, City or Town, Steta) 4 Homleide Hospital Certifying Physician: To the best of my knowledga, death occurred et the tima, data and place, and dua to tha causa(s) and mannar as stated.

| Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, deeth occurred at the tima, date and place, and dua to the cause(s) and menner stated. Medicai 29a. Certifiar \$ 29b. Signatura and Iitla of certifias 29c. Licansa number 29d. Data signed (Month, Day, Year) 10 30. Nama and address of persion who completed causa of death (Itam 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Jahr Davilson Randall Registrar

DHMH 16 Rev 6/95



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR, Riter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | or death w | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|------------|--|
| TO THE HOSPITAL OR ATTENDING PHYS | TO THE FUNERAL DIRECTOR: After this | 4 | IMPORTANT: If item 28 is marked |

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR REGISTRAR | STATE OF MARYLAND / | | NT OF HEALTH AND | MENTAL | HYGIENE REG. NO. | 0 0 | 0100 |
|---|--|---|--|---------------|---|------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Tindley A. | Logan | | | 2. DATE O | | 3. TH | ME OF DEATH |
| 030 AH 2000 | 6. AGE (In yrs. Inc.) M 2 F 79 | YRS. IF UNI | DER 1 YEAR IF UNDER 24 HRS. 8 DAYS HOURS MIN. | 7. DATE OF | Day, Year) | BIRTHPLACE Country) | (State or Foreign |
| 9a. FACILITY NAME (If not institution, give street UNIVERSILY H | e and number) OSPital | 9b. C | Himera | EATN | Balt | OF DEATH | e |
| 100. STATE 100. COUNTY VIR GIN 100 ACCUM | nac K | New | N OR LOCATION | | | | INSIDE CITY LIMITS? YES 2 K NO |
| 100. STREET AND NUMBER | 1 | 17.00 | 101. ZIP CODE | , — | 10g. CITIZEN | | |
| 3111 | 2. WAS DECEDENT EVER IN U.S. AF | | 3. WAS DECENDENT OF NISPA If yes, specify Cuben, Maxico 1 YES 2 NO Specify | an, Puarto Ri | | Specify: | |
| 15. DECEDENT'S EDUCAT (Specify only highest grade co | mpleted) (G | ECEDENT'S USUAL iive kind of work do b. Do NOT use retire | ne during most of working | 16b. | KIND OF BUSINESS/INDUS | TRY | ack |
| Elementary/Sepondary (0-12) 17. FATHER'S NAME (First, Middle, Last) | College (1-4 or 5+) | ruck c | PRIVER | F | erdue | Food | s |
| William Log | an | | G-eor | zia | William | S | |
| mavie B. L | ogan 3 | B/211 | Chinco tess | - 1 | or, City or Yown, State, Zip Co LANE New | uchu | ed va. |
| 20a.METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remove 1 Donation 6 Other (Specify) | al from State comercing | and date of dispending | | 1-27. | 20c. LOCATION - CITY | lle, | VC- |
| 21. SIGNATURE OF FUNERAL SERVICE LICEN | Mharlar | | 22. NAME AND ADDRESS OF FI WHARTAN 22171 WHA | HON! | sed Home | umae | Uh ≥3±1 |
| 23. PARTU. Enter the diseases, or co- shock, or heart fallure. Lis IMMEDIATE CAUSE (Finel | st only one cause on each line | eath. Do not en | ter the mode of dying, aud | ch aa cardi | ac or reapiratory arrea | | Approximsta interval Between Onset and Death |
| disesse or condition resulting in death) | UNKNOWN DUE TO (OR AS A CONSE | OUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate | Diffuse Athero | sclerotic ourse of: | Disease | | | | |
| cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST | DUE TO (OR AS A CONSE | OUENCE OF): | | | | | |
| PART II. Other significant conditions | contributing to deeth but not | resulting in the | underlying cause given in | Pert i. | 24a. WAS AN AUTOPSY PERFORMED? | | E AUTOPSY FINDINGS ABLE PRIOR TO |
| | | | | | 1 TYES 2 X NO | OF D | PLETION OF CAUSE EATH? YES 2 NO |
| DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLA | CE OF DEATH (Ch | ack only one) | иП | | <u></u> | |
| 1 TYES 2 NO | HOSPITAL: Inpetient 2 ER/Outpetient | 3 DOA 4 D | IER: Nursing Nome 5 Residence | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DE\$6 | CRIBE NOW INJURY OCCUP | łED | |
| 3 Suicide 8 Could not be 4 Nomicide determined | 28a. PLACE OF INJURY — At h building, atc. (Specify) | oma, tarm, street, | tactory, offica | | TION (Street and Number or or Town, State) | Rural Route I | Number, |
| and and | AN: To the best of my knowledge, d On the basis of examination and/or | | | | | | manner as stated. |
| | Madayag - M.D.) |) | 29c. LICENSE NU 07306 | IMBER | 29d. DATE S | GNED (Mon | |
| Robert Madayag, M.D. | | | p. 22 S.Green | ST.E | , Baltimore | , Md. | 21201 |
| JAN 25 1996 | 32: REGISTRAR'S SIGNATURE | | | | | | |

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| enaea | ∜⊃ , | 2/0/90, | M.W.U. | H | oward | Co. |
|-------|-------------|---------|--------|----|--------|------|
| FOI | R | | STATE | 0F | MARYLA | ND / |

| nded #5, 2/6/96, M.W. | .O. Howard Co. | | | 20 | 00 |
|---|---|--|--|-----------------|-----------------|
| 1 - FOR STATE REGISTRAR | TATE OF MARYLAND / DEP. | ARTMENT OF HEALTH AND FICATE OF DEATH | MENTAL HYGIENE REG. NO. | | |
| 1. DECEDENT'S NAME (First, Middle, Last) | Robert E. Lee | | 2. DATE OF OEATH MONTH January 28 | , 1996 | 3. TIME OF 4:20 |
| 4. SOCIAL SECURITY NUMBER 5. S 215 - 26 - 2414 | 6. AGE (In yrs. lest birthdu M 2-00 F 65 YRS | MONTHS DAYS MOUNTS ANN | 2. DATE OF BIRTH (Month, Day, Year) March 7,19 | Count | PLACE (State |
| 9a. FACILITY NAME (If not institution, give street el | nd number) | 9b. CITY, TOWN OR LOCATION OF E | DEATH | 9c. COUNTY OF D | |

| | | 1. DECEDENT'S NAME (First, Mid | | + F T | 20 | | | MON | | 28, 19 | VEAR | 3. TIME OF DEAT 4:20 | |
|---|--|--|---|----------------|----------------------|---------------|-----------------------------|--------------|----------------|----------------|--|---------------------------|----------|
| | | Robert E. Lee January 28, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH | | | | | | | | | | PLACE (State or Fo | Рм |
| | | 215 - 26 - 24 | 1/ 1XM2-0F | 65 | | MONTHS DAT | 7 | N. (Moi | nth, Day, Yea | r) | Countr | y) | reign |
| 3 should | | 9a. FACILITY NAME (If not institut | 14 / | 65 | | 9b. CITY, TOV | VN OR LOCATION O | | ch 7, | _ | MTY OF D | yland | |
| . 2, 3 sl | DIRECTOR | 8839 Baltimor | e Street | | | Savag | e | | | How | | | |
| sadi | REC | | . COUNTY | | 10c. CITY, | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY | |
| .j. 27. | | | oward | | Sava | ge | e | | | | | 1 X YES 2 | NO |
| E Sed | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZE | | | | | | | | | ZEN OF V | VHAT COUNTRY? | | |
| an. transi | FUNERAL | 8839 Baltimor | | | | | 20763 | | | USA | | | |
| 120 hysici ourial- | 5 | 1 Never Married 2 V Married FORCES? 1 X YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, stc.) | | | | | | | | | or No— 14. RACE — American Indian, Black, White, etc. | | |
| 5-0020 ending physician. as the burial-transit permit. Pages 1, 2, | В | 3 Wildowed 4 Divorced | 1954 - | | | 10 | YES 2 📉 NO S | pecify: | | | Spec | hite | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. S should be detached for use as the burfal-tran outlified at once. | GB. | 15. DECEOENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | | | | | | |
| MARYLAND 2121 retained by the hospital or att 5 should be detached for use notified at once. | COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 | | Ille. Do NOT use | retired.) | Those of working | | | | | | |
| Nospii ached | MP | Grade 10 | | Me | echanic | | | | | | of Ma | aryland | |
| YLAN by the hos be detach | | 17. FATHER'S NAME (First, Middle, | , | | | | 1.7. | 11111 | | iden Surname) | | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | B | Robert E. Lee | | | 105 MAN INC. | DDDF66 (O | | Rorab | | | | | |
| | ٩ | Barbara Lee | | | | | ore Stre | | | | | 20763 | |
| BALTIMORE, or death. Page 6 may be the funeral director, page val. | | 20e. METHOD OF DISPOSITION 1 🙀 Burlel 2 □ Cremation 3 | Ramoval from State | | CE AND DATE OF | | (Name of | | | LOCATION - | | | |
| MC direct | | 4 Donation 6 Other (Spe 21, SIGMATURE OF FUNERAL SE | | | ge Cem | etery | | 1/: | 31 S | avage, | Mar | yland | |
| ALTIMOR death. Page 6 ma e funeral director, i examiner must | | 6 1/1-11 | 1000 | | | | e and address o aldson F | | l Hom | e, P.A | | | - 1 |
| | | KINIG | Ey X helle | - | | 313 | Talbott | Ave. | Laur | el, Ma | rvla | nd 20707 | 7 |
| | | 23. PART I. Enter the disease ahock, or heap | ses, or complications that fellure. List only one cau | t ceused the | deeth. Do no ine. | t enter the | mode of dying, | auch aa ca | irdiac or re | eapiratory arr | est, | Approximation interval Be | |
| # 5 m | | IMMEDIATE CAUSE (Final disease or condition | M. 1 | - | 11. | | 1. 1. | | | | | Onset and | Daath |
| 4 5 6 | ŀ | reaulting in death) | a. Metasi DUE TO | MATIC (| CICH CH | POLET | 40 LIVE | 1 | | | | PEAC | 5 |
| 68760, precuted within and completely burial, cremati, matic event, the | _ | | · Mexissy | hokii (| l. Who | luna | | | | | | 1 year | |
| P.O. BOX 687 h certificate be executed anding physician and con Hygiene prior to burial. or other traumatic e | CERTIFICATION | Sequentially list conditions if any, leading to immediate | DUE TO | | SEQUENCE OF | y | | | | | | | |
| BOX cate be en Mysician to e prior to | ICA | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | | | | | |
| DS, P.O. BOX he death certificate be the attending physician Mental Hygiene prior to njury, or other traun | E | that initiated eventa resulting in death) LAST | DUE TO | (OR AS A CON | SEOUENCE OF) | • | | | | | | | |
| S, P. Seath attender H. Of | CEF | | d | | | | | | | | | | |
| RECORDS, P.O. BOX 68760, requires that the death certificate be executed with een signed by the attending physician and complete of Health and Mental Hygiene prior to burial, crenshows any Injury, or other traumatic event | AL | PART II. Other aignificant c | onditions contributing to | death but no | ot reaulting in | the underi | ying ceuse give | n in Part I. | | AN AUTOPSY | 24b. | WERE AUTOPSY FI | |
| ECORD puires that th signed by ti Health and I bws any In | MEDICAL | | | | | | | | | S 2 1 NO | | COMPLETION OF CO | |
| AEC requires een sign of Heat | ME | | | | | | | | | | | 1 YES 2 | 10 |
| | AN | DID TOBACCO USE | | | | | | IAIN 🗆 | | | | | |
| DIVISION OF VITAL FOR ATTENDING PHYSICIAN: The law DIRECTOR. After this certificate has be ours after death with the State Dept. Item 28 is marked, or item 23 s | PHYSICIAN: | 25. WAS CASE REFERRED TO ME EXAMINER? 1 ☐ YES 2 ∰NO | HOSPITAL: | | | OTHER: | | | | | | | |
| F V SICLAN CENTIFE THE S | HYS | 27. MANNER OF DEATH | 1 ☐ Inpatient 2 ☐ | | 3 DOA | | Home 5 № Rasider | | | OW INJURY OC | WIDED. | | |
| NG PHYS frer this ceath with | - 4 | 1 Netural 5 Pend | ling (Month, D | | INJU | RY | WORK? | | EŞCHIBE NO | W INJURY OCC | OHED | | - |
| ION NDING I the After c death |) BY | 2 Accident Inves 3 Suicide 6 Coul | d not be | F INJURY — AI | home, term, st | | | 261. LO | | eet and Number | or Rural R | loute Number, | - |
| DIVISION DR ATTENDING F DIRECTOR: After t hours after death | TED | | mined Dunding, | atc. (Specify) | | | | C/r | ly or Town, Si | tate) | | | |
| | PE | 29a. CERTIFIER (Check only | NG PHYSICIAN: To the best of | my knowledge, | death occurred | at the time, | date end place, and | due to the c | ause(e) end | menner ee stat | ed. | | |
| HOSPITAL FUNERAL WITHIN 72 | COMPLET | one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) and menner as state | | | | | | | | | | tated. | |
| TO THE HOSPI TO THE FUNER De filed within | BE C | 29b. SIGNATURE AND TITLE OF | CERTIFIER | | | | 29c. LICENSE | | | | | (Month, Day, Year) | \dashv |
| 1 | 0 8 | Micholias 14. | House has | - | | | D3850 | 09 | | ▶ Ja | mun | ~ 29 199 | 6 |
| 15+0 | | NICHOLAS W. KO | RISON WHO COMPLETED CAUS | 1065 L | TEM 27) (Type, 1 | Olly va. | 14 Phri | Coli | mhi | · mn | 216 | 44 | |
| · _ | | JAN 3 0 | 1996 Julia 21 | AS BIGHATUR | 24.11 | - VIUPE I | , , , , | | | | | / | \dashv |
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | 4 222224 | | | | OLNII | IVAIL | - 01 | DEATH | | HEG. N | U. | | |
|---|---|---------------|---|--------------------------|------------------------------|----------------------------|----------------------|---------------|--------------------|-------------------------|------------|------------------------|--------------------|------------------------|--|
| | | | 1. DECEDENT'S NAME (First) | | . 1 | | -11 | | | | 2. | DATE OF DEATH | DAY | YEAR 3 | . TIME OF DEATH |
| | | | Bohrer | | L | -ue | -119 | _ | | | | | 0 | 96 | 06:15 AM |
| | | | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In | yrs. last birthday | | | IF UNDER 24 H | | Month, Day, Year) | | 8. BIRTHPL Country) | ACE (State or Foreign |
| | 9 | | 214-28-6618 | | 1 🗆 MX 🗆 F | 67 | YRS. | MONTHS | DAYS | HOURS M | No. | ov 3, 19 | 28 | | 1D |
| | should | | 9a. FACILITY NAME (If not in | stitution, give a | treet and number) | | | 9b. CITY | TOWN | OR LOCATION C | | | | NTY OF DEA | |
| | 6623 CHRISTY ACRE CIRCLE | | | | | | | MT. | AI | .RY | | | CAF | RROLL | |
| | ← . | 5 | RESIDENCE OF DEC | | | | | | | | | | | | |
| | Pages | DIRE | | 10b. COUNTY | | | | ITY, TOWN C | | ATION | | | | 10 | 0d. INSIDE CITY LIMITS? |
| | | | WV | _ Morg | an | | Pa | w Pav | V | | | | | 1 | ☐ YES X ☐ NO |
| | permit. | RAL | 10e. STREET AND NUMBER | | | | | | | Of. ZIP CODE | | | - | | AT COUNTRY? |
| c | burial-transit | FUNE | P.O. Box 3 | 61 | | | | | | 25434 | | | USA | 7 | |
| 20 | rial-t | Ē | 11. MARITAL STATUS | Mandad | 12. WAS DECEDEN FDRCES? 1 | T EVER IN U | J.S. ARMED | 13. | WAS DE | CENDENT OF HI | SPANIC O | RIGIN? (Specify Y | es or No- | 14. RACE | - American Indian, White, etc. |
| 00 8 | the Dr | ВУ | 1 Never Married X 3 Widowed 4 Divo | | IF YES, GIVE W | | | | | SX NO S | | erro mount arc.) | | Specify: | Time, orc. |
| 21215-0020 | as th | ED E | | | | | | 1 | | | | | | wh | nite |
| 12 | | ETE | (Specify only | EDENT'S EDU | | 1 | (Give kind o | f work done i | CCUPAT during r | TION nost of working | | 16b, KIND OF B | USINESS/IND | USTRY | |
| 12 2 | | | Elementary/Secondary (0 | 1-12) | College (1-4 or 6 - | -) | | use retired.) | | | | | | | |
| AND the hosoital | detached once. | СОМР | 12 | | | | Homem | <u>aker</u> | | | | Own I | | | |
| Y E | | 8 | 17. FATHER'S NAME (First, M | | | | | | | 18. MOTHER'S | B NAME (| first, Middle, Malde | n Sumame) | | |
| RYL | of be | BE | Leslie F | | | | | | | | | e (Murr | | | |
| MAR | 5 should notified | 2 | 19a. INFORMANT'S NAME (7) | | | | 19b. MAILIP | IG ADDRESS | (Street | and Number or R | ural Route | Number, City or To | wn, State, Zip | Code) | |
| | 2 0 | - 1 | Cynthia Le | | | | 6623 | Chris | tv | Acre Ci | rcle | : Mt. A | iry, I | MD 2 | 1771 |
| E PE | × 19 | | 20a. METHOD OF DISPOSITI | | oval from State | | LACE AND DAT | | ITION (A | Verne of | | DATE 20c. L | OCATION - | City or Town | , Sista |
| 0 % | lirectr | | 4 Donation 5 Other | (Specify) | | Wo | odrow (| Cemet | erv | | 02 | /01 Pa | w Paw | , WV | |
| ALTIMORE, death, Page 6 may be | tuneral di examiner | | 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | | 00 | | | AND ADDRESS O | | | | | |
| DALTIMO Nours after death, Page 6 | fun exam | | >4/10 he | Chr | 1 And | 210 | de | | | pelli f erland, | | al Home 21502 | | | |
| afe on | by the | | 23. PART I. Enter the di | seesea, or c | proplications that | t caused t | ha death. Do | not enter | the m | er rand, | auch aa | cardiac or rea | nicetory err | not. | Approximata |
| HOURS | or remove | | ahock, or he | eart failure. | List only one cau | se on eac | h iine. | | | | | | pinalony and | 001, | interval Between |
| 100 | the the | | iMMEDIATE CAUSE (Fin disease or condition | | E. |) | | _ | | | | | | | Onset and Death |
| O THE | ompletel il, crema event, | ŀ | reaulting in death) | | DUE TO | OR AS A C | ONSEQUENCE | 0E: | LIL | ure | | | | | 2 Days |
| 58760 executed with | rial, | - | | | | | | | | | | | | | 2 Days Days |
| | | 0 | Sequentially list conditi if any, leading to immed | | DUE TO | (OR AS A C | ONSEQUENCE | OF): | | | | | | | 143 |
| BO se se se se se se se se se se se se se | | S | cause. Enter UNDERLY | NG | . Me. | tast | er tic ONSEDUENCE | Ca | и | e. | | | | | Mohths |
| J. E | the ph | Ē | CAUSE (Disease or inju that initiated events | LY . | DUE TO | (OR AS A C | ONSEDUENCE | OF): | | | | | | | 110 |
| D. Fe | Hyg 0 | CERTIFICATION | resulting in death) LAS | T | . Sof | + + | rissy. | e 5 | 91 | COH | 1 0 | | | | Legus |
| | y the att of Menta injury, | | DART II Other sincifies | | | | | | | | | | | | 1 |
| CORDS, | and h | MEDICAL | PART II. Other algolfice | A LA | a contributing to | death but | not reaulting | in the un | derlyir | ng cause giver | in Part | i. 24s. WAS A PERFO | N AUTOPSY RMED? | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| S E | signed by Health an | ă | | 4446 | rosch | 101 | ic C | ardi | 01 | Vas4 | 19/ | 1 🗆 YES | 2 NO | | OMPLETION OF CAUSE F DEATH? |
| HEC. | of Heal | | Dise | use | | | | | | | | | | 1/ | TES 2 NO |
| AL RECO | has been Dept. of 1 23 sho | Z | DID TOBACCO U | SE CONTI | RIBUTE TO CA | | | | | | AIN [|] | | | |
| A E | State D | PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | 26. | PLACE DF DE | OTHER | |) | | | | | |
| VII. | certificate the State or item | YSI | 1 TES 2 ND | | 1 Inpetient 2 | ER/Outpeti | ent 3 🗆 DOA | 4 Num | ling Hor | me 6 Realder | 10e 6 🗆 | Other (Specify) | | | |
| OR ATTENDING PHYSICIAN: The | his co | 표 | 27. MANNER OF DEATH | Dandina | 28a. DATE OF (Month, Di | INJURY ny, Ybar) | 28b. Ti | JURY | | JURY AT ORK? | 28d | DESCRIBE HOW | INJURY OCC | URED | |
| Z S | After this death with | B | | Pending Investigation | | | | М | | YES 2 ND | | | | | |
| END C | PR: A | | | Could not be | 28e. PLACE Di building, | F INJURY atc. (Specify) | Al home, larm | street, lact | ery, offi | ca | 261. | LOCATION (Street | and Number | or Rural Rout | te Number, |
| OR ATTENDING | DIRECTOR: After hours after death item 28 is ma | MPLETED | 4 Homicide | delermined | | | | | | | | | | | |
| | Alice where | 7 | 29a. CERTIFIER (Check only | IFYING PHYSI | CIAN: To the best of | my knowled | ge, death occu | rred at the H | me, det | e and place, and | dua to Ih | e cause(a) and m | nner aa state | ed. | |
| THE HOSPITAL | FUNERAL WITHIN 72 TANT: II | COM | | | | | | | | | | | | | nd manner as stated. |
| 5 | | | 296. SIGNATURE AND TITLE | | | | | | | 29c. LICENSE | | | | | onth, Day, Year) |
| | THE Fled | 8 | L.M. | Bla | to | | | | | D33 | 3) | ^ | D | 1 1 | 96 |
| F | E 2 5 | 임 | 30. NAME AND ADDRESS OF | PERSON WHI | COMPLETED CAUS | E DF DEATI | H (ITEM 27) (Tyr | e, Print) | | 222 | J 4 | 0 | | -116 | 76 |
| , 1 | | | F.M.GI | oth | THE MA | ,20 | East 11 | niversi | +u | Brkin | , R | Himore | Mr | 212 | 18 |
| V | | | 31. DATE EILED (Month, Day, | March | y RECETRA | A'S SIGNAT | URE | | - | 1-7, 11000 | 100 | 11/1/07 | 1,100 | or a | 10 |
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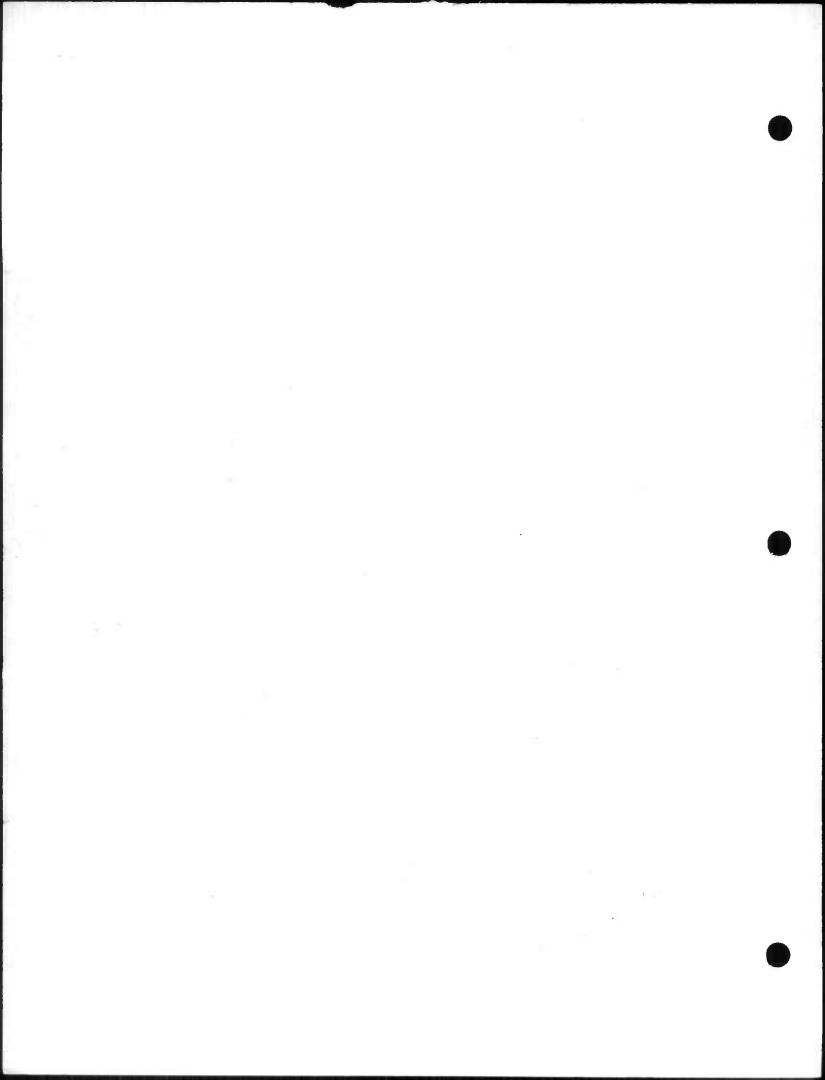
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TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|--|--|---|---------------------------------|--|---|-----------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DOROTHY MAY | LEGEER | | | | JANUARY 2 | ő, 1996 | 3. TIME OF DEATH 9:27 p M | | |
| 4. SOCIAL SECURITY NUMBER 218-12-5202 | 1 □ M 2 ½ F 7 | 73 YRS. MON | THS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 18, | 1922 Ma | | | |
| 90. FACILITY NAME (If not institution, give str Sacred Heart Hospi | | | umberl | and | ATH | Allega | | | |
| 100. STATE 10b. COUNTY WestVirginia Miner | cal | 10c. CITY, TO Ridge | wn or locati | ON | | | 10d. INSIDE CITY LIMITS? 1 K YES 2 NO | | |
| 100. STREET AND NUMBER Rt.#1 Box 258 | | | 101. | ZIP CODE 6753 | | U.S.A | OF WHAT COUNTRY? | | |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 🖾 Widowed 4 Divorced | Never Merried 2 Merried FORCES? 1 YES 2 ▼ NO | | | | | or No- 14. F | RACE — American Indian, Black, White, etc. Specify white | | |
| 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondery (0-12) | ATION completed) College (1-4 or 5+) | 16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret Personal | done during mos ired.) | t of working | Care of | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Thomas Bent | nett | | | Jeanett | ME (First, Middle, Malden e Jones | Surneme) | | | |
| 190. INFORMANT'S NAME (Type/Print) Carl Legeer 200. METHOD OF DISPOSITION | anu ann | | 258 R | idgeley, | West Virg | | 6753 | | |
| 1 N Burlel 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | val from State ceme From | etery, cremetory or other postburgMem | orialP 22. NAME AN Merrit | ark Janu D ADDRESS OF FA t-Adams | ary29,1996 GLUTY Funeral Ho | Frost | ourg, Maryland | | |
| 23. PART I. Enter the diseases, or conshort, or heart fellure. I. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | let gly one couse on ea | Parana | | da of dying, suc | | iratory arreat, | Approximate Interval Batween Onset and Death | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE OF): CONSEQUENCE OF): | | | | | | | |
| PART II. Other parificen conglitions DID TOBACCO USE CONTR | ulutl | | | uncertal | PERFO | RMED | 24b. WERE AUTOPSY FINDINGS AMMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HØSPITAL: | 26. PLACE OF DEATH (C | Check only one) | | | | | | |
| 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpetient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | 28c. INJ WO | | 6 Other (Specify) 26d. DESCRIBE HOW | INJURY OCCURE | Ю | | |
| Accident Investigation 3 Suicide 6 Could not be datermined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Yown, Stete) | | | | | | | | | |
| cool | CIAN: To the best of my know. | | | | | | use(e) end menner ee stated, | | |
| 296. SIGNATURE AND TITLE OF GERTIFIER | nuttrus | | DEG. | 333 | 29d. DATE 910 ▶ JANU | 00 | | | |
| Bichard Schmitt 10 | 0 Seton | ATH/(ITEM 27) (Type Pa | uwb | uland | and a | 20502 | | | |
| JAN 2 9 1996 | 12. REGISTRAD'S SIGN | A PLA | | | | | | | |



| | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | |
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| PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy | heat | Clar |
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| 0 | 20 | 3 |

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | Aiddle, Last) | | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF DEATH |
|---------------------------------------|--|--|--|--|--|--|---|--|--|---|--|---|------------------------|--|
| | Robe | | | | | MONTH | , 25 | | 96 | 6:501 | | | | |
| | | | | 6. AGE (In yrs. Ia | st birthday) YRS. | IF UNDER | 1 YEAR DAYS | HOURS | 4 HRS. MIN. | 7. DATE OF (Month, D. | ay, Ybar) | BIRTHPLACE (State or Fore Country) | | 1) |
| | 9a. FACILITY NAME (If not insti | itution, give s | street and number) | , , | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | ne 21,1921 Pennsylvania | | | |
| CTOR | Goodwill Men | | Grantsville | | | | | | Garrett | | | | | |
| 5 | RESIDENCE OF DECE | 1 | | | | | | | | | | | | |
| DIRE | Maryland Garrett | | | | | Grantsville | | | | | | | | 10d, INSIDE CITY LIMITS? 1 YES 2X NO |
| FUNERAL | 10e. STREET AND NUMBER | | 101. ZIP CODE 10g. CITIZEN OF | | | | | EN OF W | HAT COUNTRY? | | | | | |
| NE | 159 Killdeer | DAVED | 21536 | | | | | | - | USA | | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 M Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FDRCES? YES 2 IF YES, GIVE WAR OR DATES WW 2 | | | | | 1 1 | f yes, sp | | , Mexica: | , Puerto Rica | DIN? (Specify Yes or No — 14. RACE — An Black, White Specify: White | | , White, etc. | |
| G | 15. DECEI (Specify only i | DENT'S EDU | | 16a. Di | ECEDENT'S | USUAL O | CCUPATIO | ON ost of working | | 16b, KI | ND OF BUSINE | | | |
| | Elementary/Secondary (0-1 | 1 | College (1-4 or 5 | +) /// | e. Do NOT u | ise retired.) | | oat or working | | | | | | |
| COMPL | | | 2 | 2 Self-em | | | yed | | | | suranc | | | |
| 00 | 17. FATNER'S NAME (First, Mid | | | | | | | 16. MOTHE | ER'S NA | ME (First, Mide | tle, Melden Surr | neme) | | |
| BE | Walter Gust | | 005 | | | | | | | t Cray | | | | |
| 5 | 19a. INFORMANT'S NAME (Typ | | | | | | | | | | City or Town, Si | | | |
| | Miriam B. Loc | | | 20b. PLACE | | | | | Gr | | lle, N | | | |
| | 1 Burlel 2X Cremetion 4 Donation 5 Other (S | 3 🗆 Rem | noval from State | | | de Ci | cema | tory | | | Davids | | | |
| | 21. SIGNATURE OF FUNERAL | SERVICE LI | CENSEE | | | 22. | NAME AI | ND ADDRESS | S OF FA | HOIT | nes, P. | Δ | | |
| | * Non | w | 1 pur | 10. | | | | | | MD 2 | | • | | |
| | IMMEDIATE CAUSE IT IN | art failure. | | at caused the d | leath, Do | | | | | | | ory arre | at, | |
| IFICATION | shook, or he immediates or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter UNDERLYING CAUSE (Disease or injury that initiated events | ona, late | a. Due to | at caused the d | EDUENCE C | He OF): | | ode of dyin | | aa cardlad | | are | et, | interval Betw |
| MEDICAL CERTIFICATION | shook, or he iMMEDIATE CAUSE in a disease or condition reaulting in death) Sequentially list condition if any, leading to immedi cause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events reaulting in death) LAST | ona, late IGG | a. Due To | et caused the dune on each iin O TIVC O (OR AS A CONSE O (DR AS A CONSE O (DR AS A CONSE O (DR AS A CONSE O (DR AS A CONSE | EDUENCE C | not enter | Ua Ua | So Cu | FA) | Part i. 24 | | TOPSY | | Approximate interval Setw Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do |
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| ETED BY PHYSICIAN: MEDICAL CE | shook, or himmedisease or condition reaulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurthat initiated events resulting in death) LAST PART II. Other aignificant in the condition of the condit | ona, late IG y at condition E CONT MEDICAL rending restigation to be stermined | DUE TO DUE TO C. DUE TO C. DUE TO | et caused the duae on each iln entre view of the conservation of | EDUENCE C EQUENCE C reaulting ATH Y VCE OF DEA 28b. TH IN | ES THE AT (Check OTHER 4 (Dr. Nur ME OF) street, fect | the mo | UNCE | Laufven in | Part i. 24 1 B Other (S 28d. DESCR 28f. LOCATI City or | Sec. WAS AN AUT PERFORME YES 2 (1) | TOPSY DO? | 24b. UREO | WERE AUTOPSY PINON AMALABLE PRIOR TO COMPLETION OF CAU |
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTABILY: If them 28 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

| | | 1 - STATE REGISTRAR | OINIE OI I | C | | | OF DEA | | MENIAL RIGIEN REG. NO. | | | | |
|---------------|------|---|------------------------------|------------------------------------|--------------|------------------|---------------------------|------------|---|-----------------|---------------|--------------------|--------|
| | 1 | 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH | | | | | | | | | YEAR | 3. TIME OF DEAT | ГН |
| | | CHARLES VER | NON | LAYTON | | | | | | 28 | | 3:50 | Рм |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. la: | st birthday) | IF UNDER 1 Y | | R 24 HRS. | T DATE OF BURYLL | T DATE OF BURTH | | PLACE (State or Fo | oreign |
| | 1 | 215-38-0463 | 1 📉 M 2 🗆 F | 84 | YRS. | MONTHS D | HOURS | MIN. | OCT. 20, | 191 | L S. | " CAROL | INA |
| | 1 | 9a. FACILITY NAME (If not institution, give : | street and number) | | • | | WN OR LOCAT | ION OF D | | 9c. COU | UNTY OF DEATH | | |
| 5 | 5 | WM. HILL HEALTH CARE CENTER EASTON TALBOT | | | | | | | | | | | |
| 18 | 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | | | | | | | |
| action | | MARYLAND TALBOT EASTON | | | | | | | | | V LIMITS? | | |
| | | 106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | NO | |
| Š | | IU. ZIP CODE 10g. CI | | | | | | | | | ITE | | 70 |
| CHACOAL | | 11. MARITAL STATUS | | | RMED | 13. WAS | | | NC ORIGIN? (Specify Yes | | | | |
| Ü | | 1 Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 | YES 2 1 | NO | If ye | | ın, Mexica | n, Puerto Rican, etc.) | | | | en, |
| 2 | | 3 Widowed 4 Divorced | IF YES GIVE V | T | | 1 | 123 22 <u>8</u> NO | эрвси | r. | | | | |
| 1 6 | | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a, DE | CEDENT'S | USUAL OCCU | PATION g most of world | na | 16b. KIND OF BUS | | | | |
| i i | | Elementary/Secondary (0-12) | College (1-4 or 5 | +) life | . Do NOT u | se retired.) | ATION | | U.S. DI | | | | |
| COMPLETED | | | | BU1. | ь сс | MSEK | | | AGRICU | | Œ | | |
| | | 17. FATHER'S NAME (First, Middle, Last) CAREY O. LAYT | ON | | | | | | ME (First, Middle, Maiden BURNETT | Surname) | | | |
| D a | | 19a. INFORMANT'S NAME (Type/Print) | ON | | | | | | | | | | |
| 5 | 2 | | YTON | | 09 S | | | | ST, EAST | | | 21601 | |
| | H | 20s. METHOD OF DISPOSITION | 1101 | _ | _ | OF DISPOSITIO | | .014 | | | | | |
| | 1 | 1X Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | oval from State | cemetery, cre | matory or o | ther place) | • | ם גם | 1 | EASTON, MD | | | |
| 5 | l | 21, SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | TIMAT | | E AND ADDRE | | | 51 OIV | , 11. | | _ |
| Y | 1 | +MF Non | -10-11 | DOF | SP | NEV | NAM I | UNE | RAL HOME | , PA | | | |
| - | 4 | 23 PADT i Enter the diseases or | nem | | | 200 | S. I | IARR | ISON ST, | EAS | TON | | 601 |
| CERTIFICATION | | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate interval Between Onset and Due to (or As A consequence of): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 5 | - 18 | PART if Other algulficant condition | p contributing to | death but not r | esulting | in the under | lving cause | given In | Part i. 24a. WAS AN | ALITOPSY | 245 | WERE AUTOPSY FI | MDINGS |
| DICAL | | KGBS WID | h Um | mu | CA | F | ,, | | PERFOR | MED? | 240 | AVAILABLE PRIOR | TO |
| MED | | | | | | | | | 1 TYES 2 | NHO | | OF DEATH? | |
| | | DID TOBACCO USE CONT | RIBUTE TO CA | USE OF DEA | TH Y | S II NO | M IINC | FPTAIN | | | | 1 YES 2 I | ** |
| <u> </u> | | 25. WAS CASE REFERRED TO MEDICAL | | | | TH (Check only | | EKIZII | · | | | | \neg |
| 310 | | EXAMINER? | HOSPITAL: 1 Inpetient 2 | ER/Outpatient 3 | □ DOA | OTHER: | Home 5 □ R | esidence | 6 Other (Specify) | | | | |
| PHYSICIAN: | | 27. MANNER OF DEATH | 28a. DATE OF (Month, D | | 28b. TIM | - | INJURY AT | | 28d. DESCRIBE HOW IN | JURY OC | CURED | | |
| BY | - 10 | 1 Netural 5 Pending 2 Accident Investigation | (MONO), D | ay, reary | , inc | | WORK7 |] NO | | | | | |
| 2 0 | - 11 | 3 Suicide 8 Could not be | 28e. PLACE O building, | F INJURY — At ho etc. (Specify) | me, farm, | street, factory, | office | | 28f. LOCATION (Street a City or Town, State) | nd Number | or Rural R | loute Number, | |
| | | 4 Homicide determined | | | | | | | | | | | |
| COMPLETE | | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| - 1 | - 11 | 296. SIGNATURE AND EITLE OF CERT FIEL | | 4.4 | | | | ENSE NUM | | | - | (Month, Pay, Year) | |
| D BE | - 44 | M. wANa | 001 1 | - (V)1 | | | | 08 | 71> | • | 1/2 | 29/96 | |
| 101 | | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUS | SE OF DEATH (ITE | M 27) (Type | Print) | EA | 37 | mod N | 11/ | 24/2 | AM) | |
| | | JAN 29 199 | | R'S SIGNATURE | ntoth | | | | | 17 | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | F EVINERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | De med within 72 hours after death with the State dept. Or regate and mental regiment provides a medical examiner must be notified at once. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|---|
| TO THE HOSP | TO THE FUNE | IMPORTANT |

| 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPARTMENT | T OF HE | ALTH AND N | | GIENE G. NO. | | | | | | |
|--|--|---|------------------|---|---------------------------------|---|-------------------------------------|---|--|--|--|--|
| DECEDENT'S NAME (First, Middle, Leet) MILDRED | LO | OFLAND | | | 2. DATE OF DEA MONTH JAN | DAY 23 | 1996 | 9:05 PM | | | | |
| | SEX 6. AGE (in yrs. in and number) | YRS. WONTHS | DAYS | HOURS MIN. | | 1904 | Country) | LAWARE | | | | |
| | | | | ury, Md. | | | COMIC | | | | | |
| Salisbury Nursing & RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY WICOMIC | :O | 10c. CITY, TOWN (| OR LOCATION | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | |
| 100. STREET AND NUMBER 1514 RIVERSIDE 11. MARITAL STATUS 12. Married 2 Married | DR. | | 101. 2 | ZIP CODE | 801 | 10g. CITIZ | | HAT COUNTRY? | | | | |
| 3 🔀 Widowed 4 🗆 Divorced | . WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | ZNO | | NDENT OF HISPAN city Cuban, Maxica 2 NO Specify | n, Puerto Rican, e | ify Yea or No — | 14. RACE - Black, Specify. | American Indian, Whita, atc. | | | | |
| 15. DECEDENT'S EDUCATII (Specify only highest grade com Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) | npleted) (| DECEDENT'S USUAL O (Give kind of work done life. Do NOT use retired.) | during most | t of working | | OF BUSINESS/INDU | | RE | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) ARTHUR COLLI | SON | | | 16. MOTHER'S NA | ME (First, Middle, MATTIE | Maiden Surname) TODD | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) NORMA ROBBIN | | 196. MAILING ADDRES 26465 M | | d Number or Rural F WEBSTER | | or Town, State, Zip ALISBURY | | 21801 | | | | |
| FLEISCHAUER FUNERAL HOME POB 502 GREENWOOD, DE 19950 23. PART I. Enter the processes or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foliure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) BUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated eventa resulting in death) LAST | If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (or as a consequence or): | | | | | | | | | | | |
| PART II. Other algnificant conditions of COPD 167 | NO DOP | 2 , HX | ue | Couse given in | 10 | MAS AN AUTOPSY PERFORMED? YES 22 NO | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | |
| | 26. PL IOSPITAL: □ Inpatient 2 □ ER/Outpatient | ACE OF DEATH (Check | ER: | 5 🗆 Rasidenca | 8 Other (Spec | ily) | | | | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 28c. INJU WOR | JRY AT AK? ES 2 NO | 26d. OESCRIBE | HOW INJURY OCC | | | | | | |
| | 28s. PLACE OF INJURY — At building, atc. (Specify) | homa, farm, atraet, fac | ctory, office | | 261. LOCATION (City or Town | (Street and Number n, State) | or Rural Ro | oute Number, | | | | |
| (Check only | N: To the best of my knowledge, On the basis of axamination and/o | | | | | | | and manner as stated. | | | | |
| 296, SIGNATURE AND TITLE OF CERTIFIER | 5 mp | | | 29c. LICENSE NUI D-3981. | | 29d. DATE | 29d. DATE SIGNED (Morith, Day/Year) | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO C | .D.,1104 HEAL | THWAY DR. | ,SALJ | SBURY, | MD. | | | | | | | |
| 31. DATE PILED (Month, Day, Year) JAN 25 1996 | Julia d'author ho | rdall | | | | | | | | | | |

96-0296-045

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | | State | of Mar | yland / | Depa | rtment o | of H | lealth a | nd Me | ental Hyg | iene 9 | 5 (| 3772 | 2 |
|------------|--|----------------|---|---|-----------------|----------------|------------|-------------------------------|--------------|---------------------|------------|---------------------------------|---|------------------------------|--------------------------------------|--------|
| | | | Decedent's Name (First, Middle) | Leath | | | Cer | incate | OI I | Dealli | | | eg. No. | | 0.77 | |
| П | Physic | ian | | , Lasi) | D | | | | CII | DIIDD | | 2. Dete of Dea Month | Day | Yeer | 3. Time of Di | |
| | /Medi | | CHRISTIAN | | P. | | | ĻĔ | | EUER | | ANUAR' | 1 | | 10:19 | A . M |
| 7 | Exami | ner | 4e. Fecility Neme (If not institution, | | | 221 0 | | | | | | ation of Deeth | 4c. Count | | | |
| | | _ | PENINSULA REG | | _ | | ENT | | | SALIS | | | WICC | | | |
| | Funeral | | | 6. Sex 1 ☑ M 2 ☐ F | | In yrs. lest b | Yrs. | If Under 1 Y | eys | If Under 2 Hours | Min. | B. Dete of Birth (Month, Dey | Year) | Cou | plece (Stete or F ntry) | oreign |
| | Director | | 201-54-4586 | | | .5 | 113. | | | | | Sept. 10 | , 1970 | Pen | ylvania | |
| | d within 72 hours efter death with the Maryland jiene. I than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at | _ | Usuel Residence of Decedent 10e. Stete 10b. County | | 1 | 0c. City, To | wn or Loc | ation | | | | | | | 10d. Inside City | |
| | e M | Director | Maryland Wico | mico | | Sali | sbur | У | | | | | | | 1 ☐ Yes 2 | NO NO |
| | \$ 00 E | Sire | 10e. Street and Number | | | | | 10f. Zip Co | de | | | 1 | 0g. Citizen of | What Cou | ntry? | |
| | 23a | | 714 East Road | | | | | 218 | 0.1 | | | | US | Δ | | |
| | dea E | Funeral | 11. Marital Status | 12. Was De | | er in U,S. | 13. W | | | lispanic Orlg | in? (Spec | ify Yes or No- ican, etc.) | 14. Re | ce - Amer | can Indian, | |
| 0 | offer Nr Ha | | 1 Never Married 2 Merrie | | 2 No | | | | | | , Pueno A | ican, etc.) | Ble | ck, White | , etc. | |
| 02 | urs urs | by | 3 Widowed 4 Divorced | If Yes, G Year or | ive Detes: | ٠ | 1 | □Yes 2√√ | No | Specify: | | | | Specify: African American | | |
| 0 | 2 ho | ted | 15. Decedent | s Education | | 16 | e. Deced | ent's Usuel O | ccup | ation | | 16b. Kind of Bus | | | | - |
| 21215-0020 | | Completed | (Specify only highest Elementery/Secondery (0-12) | T |) (1-4or 5+) | | life. D | rind of work a O NOT use r | one i | dunng most d) | of working | 9 | | | | |
| 21 | filed within Hygiene. ther than | E | 12th grade | College | (1-401 5+) | lo | bore | r | | | | | Poultry | Indi | istry | |
| D | | BeC | 17. Fether's Neme (First, Middle, L | ast) | | | | | | 18. Mother | r's Name (| (First, Middle, | | | ,511.7 | |
| a | Mental Mental srked c | ToB | Stanley Edwin Le | Sueuer | | | | | | Dinet | ta Ba | essie Co | ook | | | |
| Maryland | 2 should b and Mente Is marked raumatic e | - | 19e. Informent's Neme/Reletionsh | | | 19 | b. Mellin | Address (S | treet | | | Route Number | | Stete, Z | p Code) | |
| | | | Stanley LeSueuer | | | | | | | | | | | | a 19116 | |
| a, | of Heal | | 20e. Method of Disposition | | | | | ition (Neme of | | | | | 20c. Location | | | |
| altimore, | (f) (7) | | 1 Buriei 2 Cremation | | Stele | | | | | | | | | | | |
| ₫ | Trans | | 4 Donetion 5 Other (Sp | | | Salisb | | Cremat | | | | 26/96 S | | | | |
| Ba | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funerei Service L | Icenses | | | 22. | Name end A | aare | ss of Fecility | 12 | 13 Jers | ey Roa | d - S | alisbury, | MD |
| | | | Harricen | Lou | ey | | Jo | lley Me | em | orial (| Chape | el | | | 2180 |)1 |
| | | | 23e. Part1. Enter the diseese, or o shock, or heert feilure. List of | complications that only one cause on | caused the | e deeth. Do | not ente | r the mode of | f dyin | ng, such es c | cardiec or | respiretory arr | est, | | Approximete Intervel Betwe | en |
| 1 | Physician | ı | | | | | | | | 4 | | | | | Onset and De | eth |
| | /Medical Examiner | | Immediate Ceuse (Finel diseese or condition | G | unsl | not i | Dou | und o | F | A60 | lom | en | | | | |
| в | CXAIIIIIIEI | | resulting in death) | 0. | | e to (or es | 1 | | _ | | | | | | | |
| | D .# | Examiner | | - b | | | | | | | | | | | | |
| | be exacuted ician and bunal-transit | Cam | Sequentially list conditions, | 0. | Du | e to (or es e | consequ | ienca of): | | | | | | | | |
| Ö, | e existan sian si | | Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury | | | | | | | | | | | | | |
| 8760, | icate be executed physician and s the bunal-transit | dical | thet initieted events resulting in deeth) Last | C | Du | e to (or es e | consequ | enca of): | | | | | | | | |
| 9 | onding p | Me | 111/000-0000000-7-000 | | | | | | | | | | | | | |
| Box | | an | · | 0 | | | | | | | | - | | | | |
| | ne death the atter | Sic | Part II. Other aignificent condition | na contributing to | death but r | ot resulting | in the un | derlying caus | e giv | en in Pert I. | | 23b. Did to | bacco use co | ntribute | o the cause of | death? |
| P.0 | ± 60 | Physician/Med | | | | | | | | | | 1 U Y | 08 2 No | 3 Pro | bably 4 Ur | known |
| | 8 5 8 | by I | | | | | | | | | | | / - | | | |
| Records, | v requires been sign should be | | | | | | | | | | | 24e. Wes e | | | ere eutopsy find eileble prior to | lings |
| S | - D 0 | plet | | | | | | | - | _ | | ponon | | C | ompletion of cau deeth? | se |
| æ | 0 - 0 | Completed | | | | | | | | | | 1)2(4 | es 2 No | 1 | ¥Yes 2□ No | 0 |
| Vital | dcian: The certificate rector, pag | | 25. Wes case referred to medical | | | | | | | 26 Place | of Death | (Check only or | | 1 | 5 | |
| | Physician: rthis certific | o Be | exeminer? 11∑ Yes 2 No | Hospitel: | Inpatient | 2 ER/0 | outpetient | 3□ DOA | Oth | or. | rsing Hom | | | ner (Spec | (6.1) | - |
| of | Phys r this aral di | ⊢ | 27. Menner of Deeth | 28a. Date | of Injury | 28b. | Time of | | Injur | | 1000 | ad Describe h | | | 19/ | |
| on | ding th. Afte | to | 1 ☐ Neturel 5 ☐ Pending | (Moi | nth, Day Y | (ear) | Injury 132 | AM | Injur Wor | | - 100 | ulson | + <hn< td=""><td>+</td><td></td><td></td></hn<> | + | | |
| S | Attending or death. actor: After by the fune | fica | 3 ☐ Suicide 6 ☐ Could no | ot be | a of injury | - At home | | et, fectory, of | | - | 28 | at, Lebution (S | treet end Num | / ber or Rui | al Rouje Nymbe | V |
| Division | 는 다 다 다 | Certification: | 4 Homicide determin | build | ling, etc. (| Specify) | , 0110 | Hame | | | 6 | City or Tow | n, Stete) 4/ | 35no | w Hill k | oak |
| | | | 29e. Certifier 1☐ Certifying | Dhyelolen: To th | o boot of - | av kacıda 4- | o doot | 10. | | no doto ocid | 0 | | 17, 19 | 000010- | etotod | |
| | the de la constant de | Ical | | Physician: To the xaminer: On the l | | | | | | | | | | | | |

3 State

Registrar

31. Date filed (Month, Day, Yeer)

JAN 24.1996

npleted cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

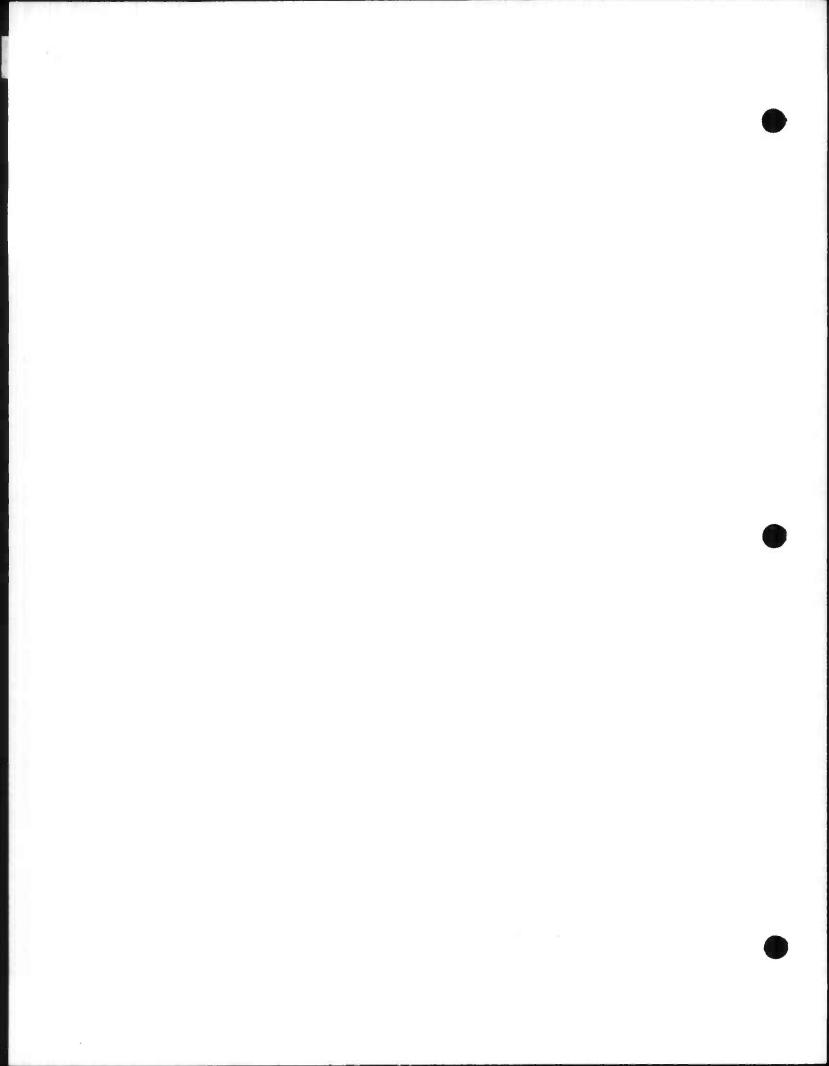
29d. Dete signed (Month, Dey, Year)

JANUARY 20,1996

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| | | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR | TMENT OF | HEALTH AND | MENTAL | HYGIENE REG. NO. | | |
|---|--------------|---|--|--|----------------------------|---|---------------|------------------------------------|--------------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE (| | YEAR | 3. TIME OF DEATH |
| | | Virginia Sha | | Larkir | 1 | | Janua | ary 19, | 1996 | 12:54 A. |
| Pin | | 219-54-5594 | □ M 2 🖾 F 4 | 6 YRS. | IF UNDER 1 YEAR MONTHS DAY | B HOURS MIN. | | 3,1949 | Nort | th Carolina |
| 2, 3 should | TOR | 90. FACILITY NAME (If not institution, give stree Suburban Hospital | t and number) | | | n on Location of D hesda | EATH | | Montgo | |
| ft. Pages 1, | DIRECTOR | 10e. STATE 10b. COUNTY | ntgomery | | y, town on Lo | | | | - | 10d. INSIDE CITY LIMITS? 1 |
|). insit permit. | ERAL | 3708 Raymond Stre | et | | | 101. ZIP CODE 2081. | 5 | | U.S. | WHAT COUNTRY? |
| 5-0020 nding physician. is the burial-transit | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 1 NO | If yes. | DECENDENT OF HISPA, apecify Cuban, Mexico | an, Puerto Ri | | Spe | E — American Indian, ck, White, etc. city: 11te |
| ND 21215-0 hospital or attending ached for use as the ce. | ETED | 15. DECEDENT'S EDUCAT (Specify only highest grade co | | 16a. DECEDENT'S (Give kind of life. Do NOT u | work done during | ATION most of working | 16b. | | IESS/INDUSTRY | |
| AND the hospita detached once. | COMPL | 12 | 2 | compute | rs | | | N.I.H | 1. | |
| d | 8 | 17. FATHER'S NAME (First, Middle, Lest) | 1-2 | | | 18. MOTHER'S NA | | | * | |
| IARYL, tained by th should be d | H | Lawrence C. Lar | Kin | | ADDDESO (0) | | | Bennett | | |
| 5 5 5 | ٤ | Lawrence C. Lar | | 3708 | Raymon | d St., Che | vy Cha | ase, Mo | 1. 2081 | |
| e 6 m metor, | | 20a. METHOD OF DISPOSITION 1 □ Purial 2 □ Cremation 3 □ Remove 4 □ Denation 8 □ Other (Specify) | il from State Ga | PLACE AND DATE | eaven C | emetery Ja | | 96 Sil | tion - chy or 1 Lver Sp | ring, Md. |
| - CO | | 21. SIGNATURE OF FUNERAL SERVICE LICEN | 30/61 | 1 | De 22 | e and address of FA Vol Funera 22 Wiscons | al Hor | veN.V | V. Wash | .DC 20007 |
| hours after of in by the or removal. | | 23. PART I. Enter the diseasea, or con ahock, or heart failure. Lie | nplications that caused it only one cause on e | the death. Do ach line. | not enter the | mode of dying, aud | ch as cardi | ac or reapira | tory arrest, | Approximate Interval Between Onset and Death |
| nety fill nation | | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Vanh | ventr | | fibrilla | tion | | | 10 minute |
| executed with and complete b burial, crematic matic even | _ | | myocardial | | • | | | | | 1 hour |
| OX 68 OX 68 ician and crior to buri | 9 | Sequentially list conditions, if any, leading to immediate | | CONSEQUENCE O | | | | | | |
| ate be e sysician prior to | S | cause. Enter UNDERLYING CAUSE (Disease or Injury | coronary a | | | | | | | 10 years |
| S, P.O. Boddeath certificate attending physiene primal Hygiene prima, or other ti | ERTIFICATION | that initiated events resulting in death) LAST | insulin de | pendent | , | es mellit | us | | | 20 years |
| 0 65 = | CAL C | PART II. Other algnificant conditions | contributing to death b | out not reaulting | In the underl | ying cause given in | Part 1. | 24a. WAS AN AL PERFORM | ED? | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 의 금 = = 6 | MEDIC | | | | | | | 1 - YES 2 0 | gNO | OF DEATH? 1 YES 2 NO |
| AL H law re has bee Dept. o | PHYSICIAN: | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL | BUTE TO CAUSE O | OF DEATH YI | | | N 🗆 | | | |
| F se E | 100 | EXAMINER? | IOSPITAL: | | OTHER: | | | | | |
| Sicial certification the | H | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. Til | E OF 28c. | Home 5 Realdence | | | URY OCCURED | |
| NG PHYS fler this eath with | ВУ Р | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | IN. | M t | WORK? | | | | |
| TTENDI TOR: A after d | 0 | 3 Suicide 8 Could not be determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, ferm, | street, fectory, c | office | | TION (Street end r Town, State) | d Number or Rural | Ploute Number, |
| AL DIRI | COMPLET | and! | AN: To the best of my know | | | | | | | |
| OSPI UNER VITHIN | 8 | 2 MEDICAL EXAMINER: | On the beals of examinatio | n end/or investigati | on, in my opinio | | | and place, and o | due to the cause | (a) and manner as stated, |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 I | TO BE | 296. RIGHATURE AND TITLE OF CERTIFIER | _MO | | | 29d. LICENSE NUMBER D37678 29d. DATE SIGNED (Month, Day, Year) ▶ January 19,1996 | | | | |
| | | Dr. Mackin, 5401 W | estern Aven | ue,N.W., | | gton,DC 20 | 0016 | | | |
| | | JAN 3 0 1996 | | | - | | | | | |



permit. Pages 1, 2, 3 should and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit a burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician, notified at 2 must examiner hours after death. medical the traumatic event, requires that the death certificate be executed with the attending physician a Mental Hygiene prior to other t 0 Health and I ашу has been : Dept. of H OR ATTENDING PHYSICIAN: The tem certificate h 0 this c marked, After 1 death 99 DIRECTOR: TO THE HOSPITAL
TO THE FUNERAL (
Be filed within 72 h
IMPORTANT: If II HOSPITAL

96 03774 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 01 60 1996 January 27, 10 3:48 p M 5. SEX 6. AGE (In yrs. hist birthday 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS 1 🔯 M 2 🗌 F 559-53-6856 June 26, 1922 Philippines 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 9620 Kanfer Court Gaithersburg Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b COUNT 10c. CITY, TOWN OR LOCATION Maryland Montgomery Gaithersburg 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9620 Kanfer Court 20879 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE - American Indian, Black, Whita, etc. FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 TYES 2 X NO Specify: 3 Widowed 4 Divorced WWII Filipino COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer TV Repair & Appliances 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) Enrique Litonjua Maria Valderama BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lilia Litonjua 9620 Kanfer Court, Gaithersburg, MD 20877 20e. METHOD OF DISPOSITION

1X Burial 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Forest Oak Cemetery 1/30/96 Gaithersburg, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Tichael Gaithersburg, MD 20877 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final Onaet and Death** disease or condition_ Klanoma resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER 1 | Inpatient 2 | ER/Outpatient 3 | DOA Home 5 Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO B 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On on and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFICE 29d. DATE SIGNED (Month, Day, Year) BE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

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JAN 3 0 1996

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene O.C.

| | Dhamis | | Decedent'a Nama (First, Middla, L | ast) | | | | | 2. Data of Deat Month | eg, No. h Day | Year | 3. Tima of Death | | | | |
|---------------------|---|----------------|---|---|---|-------------------------------------|-----------------------------------|---|---|--|--------------------------------|-----------------------------------|--|--|--|--|
| | Physici /Medi | | JAMES F. LYNN | | | | | | JAN | 27, 19 | | 6:00 P.M. | | | | |
| a | Examir | ner | 4a. Facility Nama (If not institution, g | iva street and number |) | | | 4b. City, Town, or I | | 4c. County | | | | | | |
| н | | | SPRING HOUSE 5. Social Security Number 6. | Sax 7. A | ga (in yrs. last | hirthday) If L | Indar 1 Yaar | BETHESDA If Under 24 Hrs. | | | OMERY | on (Chata on Foreign | | | | |
| | Funeral Director | | 382-12-7110 Usuel Rasidance of Decedant | 1 2 M 2□ F | 91 | | nths Deys | Hours Min. | 8. Data of Birth (Month, Day, FEB. 22 | Year) , 1904 | Country MICHIC | ca (State or Foreign CAN | | | | |
| | death with the Maryland ms 23a or 28a-f show Linual be notified at | | 10a. Stata 10b. County | | 10c. City, To | own or Location |) | | | | 10d | . Inside City Limits | | | | |
| | the Maryle 28a-f shor | Director | MARYLAND MONTGOM | ERY | BETHE | | | | | | | 1 ☐ Yes 2 No | | | | |
| | th with t | | 10e. Straat and Number | | | | f. Zip Code | | | Og. Citizan of V | Vhat Counfry | 7 | | | | |
| | ter death w | Funeral | 5228 ELLOITT ROAD 11. Meritei Status | 12. Was Decedent | Ever in U,S. | | 0816 Decedent of H | lispanic Origin? (S an, Mexican, Puart | | .S.A. 14. Rac | e - American | Indien, | | | | |
| Maryland 21215-0020 | or its | þ | 1 ☐ Navar Married 2 📉 Marriad 3 ☐ Widowed 4 ☐ Divorced | Armed Forcas' 1 ☐ Yes ② If Yas, Giva Yeer or Defas: | | | specify Cuba as 2 XNo | | o Rican, atc.) | Specify | k, Whita, etc | | | | | |
| 5-0 | n 72 hours "natural". | Completed | 15. Decedent's I (Specify only highast g | Education rade completed) | 10 | 6a. Decedent's | of work dona | during most of wor | kina | 16b. Kind of Bu | usinass/Indu | itry | | | | |
| 121 | within ene. | dmo | Elamenfary/Sacondary (0-12) | Collaga (1-4or | | lifa. DO No | OT usa retired | 1) | | II C CO | Wenwi | PNT | | | | |
| d 2 | Hygi other | Be Co | 17. Father's Name (First, Middla, Las | | | ATTORNE | I | 18. Mother's Nan | na (First, Middla, I | U.S. GO Maiden Sumam | | SNI | | | | |
| ylar | s 1 end 2 should be filed within f Heelth and Mental Hygiene. tem 27 is marked other than other treumatic event, its Me | To B | WILLIAM LYNN | | | | | KATHERI | NE SHEE | N | | | | | | |
| Man | | | 19a. Informanf'a Name/Ralationship | (Type, Print) | | _ | | and Number or Ru | | | | ode) | | | | |
| | 1 end Heelth em 27 ther t | | PHYLLIS LYNN 20a. Mathod of Disposition | | | of Disposition | | RD, BETH | | 20c. Location - | | Ctote | | | | |
| mor | ages ent of rt: If it y or o | | | Removel from Stata | | itary, crematory | or other plea | | | | | | | | | |
| Baltimore, | permit. Pages 1 end 2 Department of Heelth s Important: If item 27 li any injury or other tre | | To Burial 2 Cramation 3 Removel from Stata 4 Donation 5 Other (Spacify) MT. OLIVET CEMETERY 1/31/96 WASHINGTON, D.C. | | | | | | | | | | | | | |
| 8 | 88 = 88 | | The population of Survive Licensee MT. OLIVET CEMETERY 1/31/96 WASHINGTON, D.C. 22. Nama and Address of Facility JOSEPH GAWLER'S SONS, INC. 5130 WISCONSII N.W, WASHINGTON, D.C. 20016 | | | | | | | | | | | | | |
| | and a | | 23a. Pert & Enter tha diseese, or col shock, or heert failura. List onl | | | A | pproximeta itarval Between | | | | | | | | | |
| | Physician Medical | | Onset er | | | | | | | | | | | | | |
| 1 | Examiner | | Immediate Causa (Final diseasa or condition rasulting In daath) Dua to (or as a consequence of): | | | | | | | | | | | | | |
| | | Jer | | | Dua to (or as | a consequance | 9 of): | | | | | | | | | |
| | ificate be executed g physician and as the buriel-transit | Examiner | Sequantially list conditions, | b | Dua to (or as | a consequence | of): | | | <u> </u> | | | | | | |
| 68760, | be ex ician i | alE | Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disaas or injury that initiated events Dua to (or as a consequence of): | | | | | | | | | | | | | |
| 687 | ifficate g phys | edical | resulting in death) Last | | Dua to (or as | a consequence | of): | | | | | | | | | |
| Box | deeth certi e ettending ed for use a | M/us | | d | | | | | | | | | | | | |
| | he ett | Physician/M | Part II. Other eignificant conditione | contributing to death b | out not resulting | g in tha undarly | ing cause giv | an in Part i. | 23b. Dld to | bacco use cor | ntribute to th | ne cause of death? | | | | |
| P.0 | requires that the deeth cert een signed by the ettendin hould be detached for use | Phy | | | | | | | 1 □ Y | 20 No | 3 Probab | bly 4 Unknown | | | | |
| ds, | 8 6 8 | d by | | | | | | | 24e. Wes e | o eutopey | 24h Wara | autopsy findings | | | | |
| Records, | 20 00 | Completed | | | | | | | perform | | aveila | abla prior to eletion of causa | | | | |
| | The law ste hes b page 2 s | ошо | | | | | | | 1 🗆 Ya | s 2 No | of dea | res 2□ No | | | | |
| of Vital | | BeC | 25. Was casa rafarred to medical | | | | | 26. Placa of Dea | th (Check only on | | | | | | | |
| > 5 | | To | axaminar? 1 ☐ Yas 2€ No | Hospital: 1 Inpati | | Outpatient 3E | DOA Oth | er: 4 Nursing H | ome 5 Reside | ence 6 Oth | ar (Specify) | | | | | |
| | Ing P | ion: | 27. Mannar of Death ty□Natural 5 □ Pending | 28a. Data of Inju (Month, Da | ay Year) 28t | o. Tima of Injury M | 28c. Injur | yat k? Yas 2 □ No | 28d. Describe ho | w Injury occurr | red | | | | | |
| Division | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | Accidant invastigation Sulcida 6 Could not datermine | 28a. Place of in | jury - At homa, ic. <i>(Specify)</i> | | | 7a5 2 110 | 28f. Location (St City or Town | | er or Rural R | louta Number, | | | | |
| | To the Hospital within 24 hours a To the Funeral I completely filled | edical C | 29a. Cartifiar 1 Certifying P (Check only one) 1 Medical Exa | hysician: To the best miner: On the basis o and manner st | f axamination | lge, death occu and/or invastiga | rred at the tin atlon, in my o | na, data and place pinlon, daeth occu | , and dua to tha ca rred at tha tima, de | ausa(s) end <i>m</i> a ata and placa, | nnar es state and dua to th | ed. a causa(s) | | | | |
| | To th To th comp | Me | 29b. Signature end titla of certifier | , 11 | 121 | | 29c. Licens | e number | 2 | 9d. Data aigne | d (Month, Da | y, Year) | | | | |
| | | | Day to | 24 Mrs. | me | | 01 | ソフフノ | | 1-29 | -96 | | | | | |
| | | | 30. Nama and address of person who | | | | | | | | | | | | | |
| | | | DR. DAVID G. LUT | TRANCER | 5530 W | TCCONCT | N AVE | , CHEVY | CHASE | MD 208 | 115 | | | | | |

DHMH 16 Rev 6/95

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| THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death confident be executed within 24 hours after death. Page 6 may be retained by the hosp. TO THE FUNERAL DIRECTIVE After this certificate has been signed by the attending physician belied within 72 hours after death with the State Degr. of Health and Mental Hygiene prior to build, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| - India |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | RTMENT OF H | | MENTAL | HYGIENE | E | |
|---------------|--|---|------------------------|--|------------------------------------|--------------|------------------------------------|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 4.4 | | | OF DEATH | | 3. TIME OF DEATH |
| | ELLEN | ELISE | | Mul | | Jan | uary. | 28 199 | 8:10 pm |
| | 4. SOCIAL SECURITY NUMBER | | In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS, HOURS MIN. | 7. DATE C | OF BIRTH, , Day, Year) | 8. | SIRTHPLACE (State or Foreign Country) |
| | 214-28-8570 9e. FACILITY NAME (If not institution, give str | | 64 YRS. | | OR LOCATION OF D | Sept. | . 2, 1 | | ARYLAND |
| DIRECTOR | PENINSIILA REGIONA RESIDENCE OF DECEDENT | | INTER | | SBURY | EAIN | | 9c. COUNTY WICO | |
| REC | 10e. STATE 10b. COUNTY | | | TY, TOWN OR LOCAT | TION | | | | 10d. INSIDE CITY LIMITS? |
| | | MERSET | | UPPER FA | | | | | 1 YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | D 0045 | | 10 | . ZIP CODE | | | 1.0 | OF WHAT COUNTRY? |
| NE I | 27209 NEVETTE MUI | | | | 21867 | | | | .S. |
| BY FU | 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | ecity Cuban, Mexico 2 NO Specia | en, Puerto R | | or No 14. | RACE — American Indian, Black, Whita, etc. Specify: WHITE |
| 8 | 15. DECEDENT'S EDUC (Specify only highest grade | :ATION | 16a. DECEDENT'S | S USUAL OCCUPATION Work done during mo | ON | 16b. | KIND OF BUS | INESS/INDUST | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 +) | life. Do NOT | work done during mo use retired.) | ist of working | | | | |
| MP | 11 | | SCHOOL | BUS DRI | | | | DRTATIO | DNN |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | _ | | | 18. MOTHER'S NA | | | Surname) | |
| BE | PHILIP O. LAYFIEL | .D | | | MARY H | | | | |
| 2 | 19a, INFORMANT'S NAME (Type/Print) | | | G ADDRESS (Street a | | | | | |
| | NEVETTE MUIR, SR. | | | 9 NEVETT | | | - | | 1D. 21867 |
| | 1 M Surial 2 Cremation 3 Remo | | | other place) LY CEMET | | DATE | | | or Town, State |
| | 21. SIGNATURE OF PUNERAL SERVICE LICE | | ITU LAUT | | ND ADDRESS OF FA | | TIUPPE | R FAI | RMOUNT, MD. |
| | · Janes of | alexine) | 100295 | | N FUNERA | | | AND IT A | D 040E0 |
| | 23. PATT I. Enter the diseases, or c | omplications that caused | the death. Do | | OMERSET A | | | | |
| | ahock, or heart fellure. I | List only one ceuse on ea | nch line. | | | | | | Onset and Death |
| | disease or condition resulting in death) | Carde | ac a | nese | | | | | |
| | | DUE TO (OR AS A | | OF): | 1 - | | | | |
| NO | Sequentially list conditions, | DUE TO OM AS A | JANO ONSEQUENCE | ery a | lisiese | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | . (| / | 0 | | | | | İ |
| F | CAUSE (Disease or injury thet initiated events | DUE TO (OR AS A | CONSEQUENCE | OF): | | | | | |
| ERT | resulting in death) LAST | | | | | | | | |
| | PART II. Other eigniticent conditions | 6 contributing to death b | ut not resulting | in the underlyin | n ceuse niven in | Part I | 24a. WAS AN | ALITOPSY | 24b. WERE AUTOPSY FINDINGS |
| CAL | Supra Vals | | Tie . | stina | 0/0 | | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | July on the state of | WW - 1111 | | 2000 | | _ | 1 TYES 2 | NO | OF DEATH? |
| | DID TOBACCO USE CONTR | RIBUTE TO CAUSE O | F DEATH Y | ES 🗆 NO F | UNCERTAI | ND | | | 1 YES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | ATH (Check only one) | 2 01102111111 | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outp | atient 3 60A | OTHER: | ne 5 🗆 Residenca | 6 🗆 Other | (Specify) | | |
| PHY | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 26b, TI | ME OF 26c. IN. | JURY AT | 1 | | JURY OCCUR | ED |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | (Monor, Buy, Today | " | | YES 2 NO | | | | |
| COMPLETED E | 3 Suicide 6 Could not be 4 Homicide determined | 26a. PLACE OF INJURY building, etc. (Spec | — Al home, farm, | , street, fectory, offic | | | ATION (Street a or Town, State) | nd Number or I | Rurel Route Number, |
| J. | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my knowl | ledge, death occur | rred at the time, date | and place, and du | e to the cau | se(a) and men | ner sa stated. | |
| MO | one) — | R: On the beele of axamination | | | | | | | suse(s) and menner es stated. |
| Ö | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NU | MBER | | 29d. DATE SI | GNED (Month/Day, Year) |
| 0 | antial | das por | 2 | | D19. | 289 | 1 | 1 | 129/96 |
| 입 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | | | | 0 | 2 | - | 1 |
| | Chay Von 2. 0 | Kagb m. | D. P.C | , Box | 26,36 | So | alish | ury. | MD 2180/ |
| | 31. DATE FILED JANS 10 1996 | Jahren Day Sign | Mardell | | | | | | |

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funeral director, page 5 should be detached for use as the burial-transit

the medicai

31. DATE FILED (Month, Day, Year)

IAN 3 0 1996

32. REGISTRAN'S SIGNATURE

notified at once.

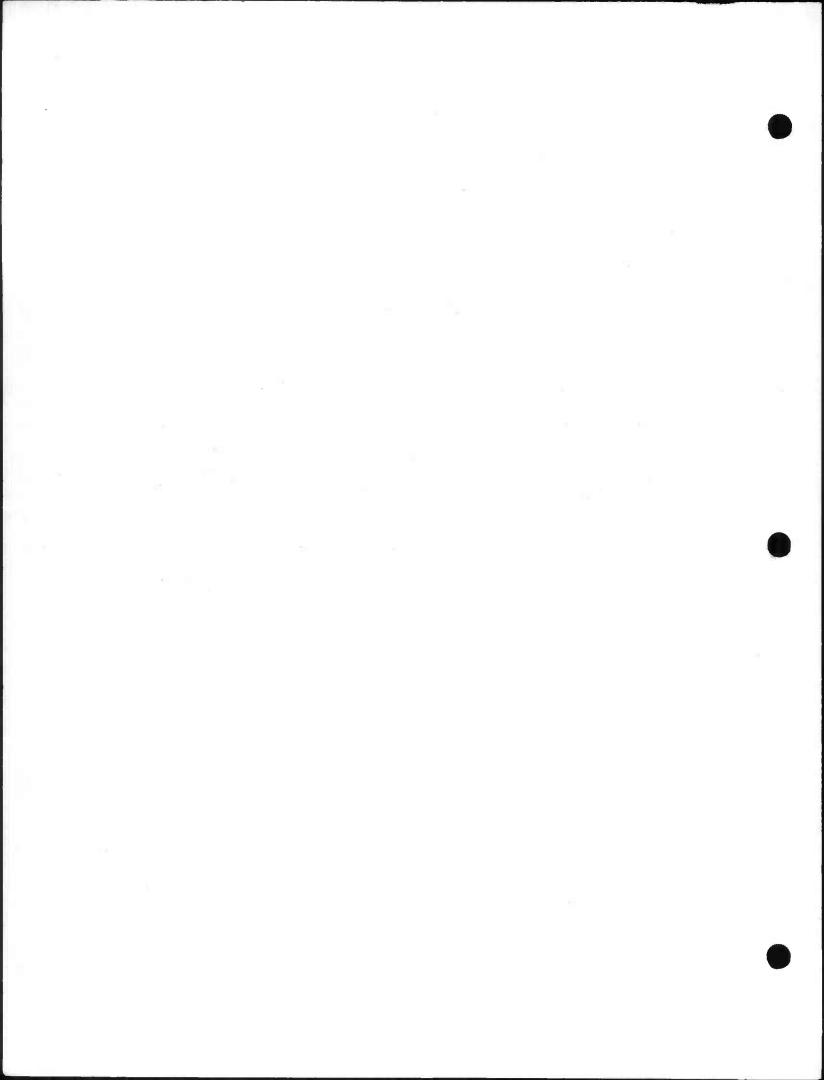
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examiner must

permit. Pages 1, 2, 3 should

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| | 24 2 | ille | ou, | he |
| 0 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by t | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remov | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical |
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| ŏ | e pe | ician | nor te | hraun |
| .0 | Uficate | phys | ene p | ther |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | death | after | ental | ny, 0 |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY 25 JANUA 1996 8.55 JOHN 0 7. DATE OF BIRTH (Month, Day, Year) 4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 578-42-4926 1 K M 2 | F 62 March 17, 1933 Washington, DC SOUTHERN M. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MARYLAND HOSPITAL PNINCE DIRECTOR GEONUES RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Camp Springs 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER tor, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6710 Geneva Lane 20748 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, Whita, etc. FORCES? 1 YES 2 1 Naver Merried 2 XMarried Specify: White YES 2 KNO Specify: ВУ 11 3 1954 3 Widowed 4 Divorced 1/54-11/54... COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-t2) College (1-4 or 5+) Construction 12 Builder/Contractor 0 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Frank McDonald Ethel Pearl Miller 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9 John W. McDonald, II 7212 Beverly St., Annandale, VA 22003 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name 30, 1996 cemetery, cremetery, cremetery or other place) Jan 30, 1996 20c. LOCATION - City or Town, Steta Lee Crematory or other place) Clinton, MD 11. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. 22. NAME AND ADDRESS OF FACILITY Clinton, MD 20735 23. PARTIL Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximsta Interval Batween Onset and Death IMMEDIATE CAUSE (Final 2-3 HRS disease or condition PULMONARY EMBOLISM DOSS. resulting in death) pulmonary infettrate CERTIFICATION Sequentielly list conditions, If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 🔀 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — Al home, farm, strast, factory, offica building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) 8 Could not be determined COMPLETED 4 Nomicide 29e. CERTIFIER 1 🔀 CERTIFYING PNYSICIAN: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(e) end manner as stated. 2 [] MEDICAL EXAMINER: On the Besia of axe tion and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(s) and manner as stated. TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE rocergo 41106 larles AOORESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Typol Print) MI 9 NAKUSO F INCOMES OF PERSON



Please Type or Print in Black Indelible Ink. Assure All Copies Are Logical Amended#20C, 01/30/96, SW, Calvert Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day **Physician** 4b. City, Town, or Location of Death 27, 1996 4c. County of Deeth /Medical JOSEPH MORELAND 6:04PM 4e. Facility Neme (If not institution, give street end number) **Examiner** Prince Georges General Hospital Cheverly Prince Georges 8. Dete of Birth (Month, Dey, Year) Mar 12,1961 If Under 1 Year If Under 24 Hrs. | Months Deys Hours Min. 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) **Funeral** Deys 34 Director 213-92-5954 Maryland Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturel", or items 23e or 28e4 show traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Lothian 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1150 Marlboro Road 20711 USA Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced white Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry I Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) truck driver, self empl. 10 transportation permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth eny liquiry or other traumatic event 2008. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Elmer A. Moreland II Virginia Fowler 19e. Intorment's Neme/Raletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Coda) Norita M. Moreland/ wife same as # 10 above 20b. Piece of Disposition (Nama of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Steta Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Switland, MD Dunkirk So. Memorial Gardens 02/01/96 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Eunerel Service Licenses Rausch Funeral Home, P.A., Owings, MD 20736 in pleations that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, the cause on each line. 23e. Pert1. Enter the disease, or dome shock, or heart teilure. List driv Approximete therval Between Onset end Peeth Physician Immediata Causa (Final disease or condition resulting in deeth) /Medical **Examiner** Dua to (or es e consequence ot) by Physician/Medical Examiner The law requires that the death certificeta be axecuted tha bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot) Box 68760, ettending physician Due to (or es e consequenca ot) 98 for use P.0. be deteched nificant condition 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Was case referred to medical Death (Check only one) Hospital: Other Certification: To 1 TYes 200ANO 2 ☐ ER/Outpatient 3D DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Division or Attending 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident the 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida Hospital 29a. Certific Medicai 1 vertifying Physician: To tha best ot my knowledga, death occurred et the time, deta and place, and dua to the causa(s) end menner es stated. completely 2 Medical Exeminar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and marrier stated. within 2 To the ŝ 29b. Sign 29c. License number 29d. Dete signed (Month, Dey, Year) 0 30. Name and address of person who completed cause of deeth (itam 23e) (Type, Print) 10

DHMH 16 Ray 6/95

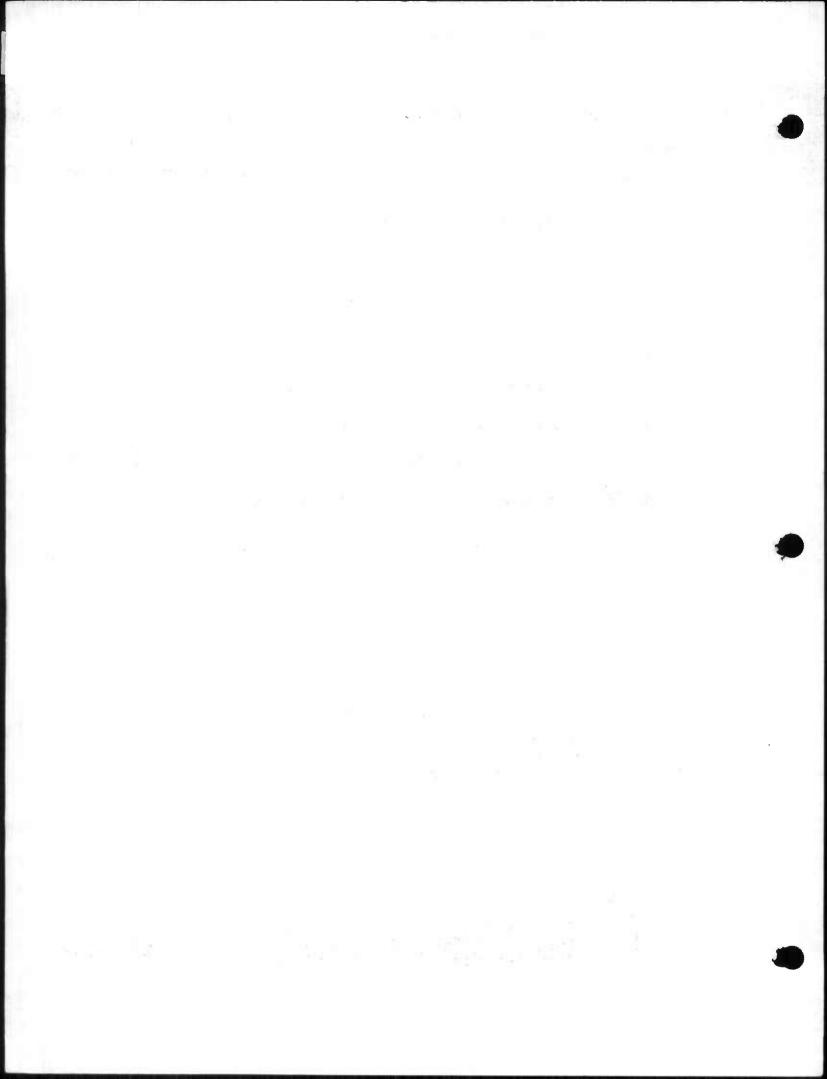
State

Registrar

31. Dete tiled (Month, Dey, Year)

32. Registrer's Signeture

Ilia Davidson Rardall



3. TIME OF DEATH

630 p a. BIRTHPLACE (State or Foreign Country)

> > Approximata Interval Between Onset and Death MONTHS

24b. WERE AUTOPSY FINDINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

2. DATE OF DEATH

January 25 1996

| _ | | 577 40 2954 | BER | t ☐ M 2 💇 F | 6. AGE (In | yrs. last | YRS. | MONTHS | DAYS | HOURS | MIN. | 7. DATE O (Month, April | F BIRTH Day, Year) 30, 19 | 928 | Country | NACE (State or Foreign Sylvania |
|--|---------------------------|--|--|---------------------------|------------------------------|-------------------|--------------|--------------|-----------|-----------------------|-------------|-------------------------------|---------------------------------|-------------|-------------|---|
| 3 should | | 9s. FACILITY NAME (# not is | | | | | | 9b. CIT | Y, TOWN | OR LOCAT | | | • | | NTY OF DE | - |
| 2, | CTOR | 1070 Clay Ham | | d | | | | Prir | nce I | reder. | ick | | | Cal | vert | |
| es 1 | <u> </u> | RESIDENCE OF DE | 10b. COUNTY | r | | | 10c, CIT | y, TOWN | OR LOC | ATION | | | | | | 10d, INSIDE CITY |
| permit. Pages 1, | DIRE | Maryland | Calver | t | | | Prin | œ Fr | reder | rick | | | | | | LIMITS? |
| it per | FUNERAL | 100. STREET AND NUMBER | | land. | | | | | 1 | of. ZIP COD | | | | | | HAT COUNTRY? |
| Han. | NE | 1070 Clay H | A DOME | t2. WAS DECEOEN | IT EVED IN | 10 404 | 450 | 140 | W# 0 D | 20678 | | 10.0010111 | | | ed Sta | |
| 215-0020 attending physician. se as the burial-transit | B | t Never Married 2 3 Widowed 4 Dive | | FORCES? 1 | YES | 2 XN | | | If yes, | pecify Cubi | an, Mexicar | 1, Puarto Ri | (Specify Yes | or No — | | — American Indian, White, stc. hite |
| | 日日 | | CEDENT'S EDUC | | 1 | 16a. DEC | EDENT'S | USUAL C | during r | TION nost of world | dna | 16b. i | UNO OF BU | SINESS/INC | USTRY | |
| 2 e 5 | once. COMPLETED | Elementary/Secondary (| 0-12) | College (1-4 or 5 | | Me. | Do NOT us | se retired.) | | | | | | | | |
| LAND the hospit | OMC. | 12 17. FATHER'S NAME (First, A | Airfello Looth | | | ооо кі | keepe | r | | | | | use of | | esenta | tives |
| | - | John Cannon | WOONE, CASI) | | | | | | | 100 | | | ddle, Malden | | | |
| | 1111 | 19a. INFORMANT'S NAME (| Type/Print) | | | 19h | MAILING | ADDRES | S /Street | | | ne Bea | r, City or Tow | o State 7ir | Codel | |
| Z 5 10 | TO BI | Sherrie Becraf | - 111 | | | | | | | | | | and 20 | | (0000) | |
| | 2 | 20a. METHOD OF DISPOSIT | TION | - | 20b. P | LACE A | ND DATE | OF DISPO | SITION | Name of | JUNE 1, | DATE | 7 | CATION — | City or Tov | rn, Steta |
| MOF age 6 m director, | must | 5 ☐ Burial 2 ☐ Crematile 4 ☐ Donation 5 ☐ Othe | | oval from State | Sou | ecy, cren | natory or or | ther place | Gar | Januar Cens | ry30, | 1996 | | irk M | | |
| Fage ral direct | iner | 21. SIGNATURE OF FUNERA | AL SERVICE LIC | ENSEE | | | | T | | AND ADDRE | ESS OF FAC | | | | | |
| ALTIMOR death. Page 6 ma s funeral director, p. | exam | L D KO | usc | | | | | 144 | IOE T | | - T- 1 | | usch F | | | |
| m after m | medical | 23. PART i. Enter the o | disesses, or o | compilestions the | ot caused t | the dea | ith. Do n | | | | | | | | | and 20676 |
| within 24 hour spletely filled is cremation, or | event, the me | immediate Cause (Fi disease or condition resulting in death) | nei | a. METATA DUE TO | | 51 | MAZ (| (C) | FLL | CARC | (1~00 | 44 0 | FT | ₹ 2v. | N G | Interval Between Onset and Das |
| Certificate be executed physician and Hygiene prior to bur | or other traumatic | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | | | |
| ORD: that the th and M | any injury. | PART II. Other algorifica | ent condition | a contributing to | death but | t not re | eulting | in the u | nderlyi | ng ceuse | given in | | PERFOR | MED? | | WERE AUTOPSY FINDING AWARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| REC requires ween sign of Healt | shows : ME | DID TOBACCO U | ISE CONITI | DIDLITE TO CA | LISE OF | DEAT | ILL VE | c ITV | NO | 7 HM/ | CERTAIN | | | | | 1 YES 2 NO |
| AL has be bept. | ICIAN: | 25. WAS CASE REFERRED T | | KIBUTE TO CA | | | OF OEAT | | _ | | CEKIAIN | <u>ч</u> Ц | | | | |
| 一一品前 | SICI/ | EXAMINER? | | HOSPITAL: | | | | OTHE | R: | | anidanaa | 8 🗌 Other | (Specific) | | | |
| OF VI PHYSICIAN: this certific with the Si | marked, or It BY PHYSI | 27, MANNER OF DEATH | Pending | 28a. DATE OF (Month, E | INJURY | | 28b. TIM | | 28c. II | JURY AT | | | RIBE HOW I | NJURY OC | CURED | |
| ISION TTENDING TOR: After after death | Z8 is | 2 Accident 3 Suicide 8 4 Homicide | Investigation Could not be detarmined | 28a. PLACE C building, | OF INJURY - etc. (Specif) | - At hon | ne, farm, s | street, fac | | | NO. | | TION (Street : Town, State) | | or Rural Ri | oute Number, |
| DI OR IL DIR | 필립 | anal . | | CIAN: To the best of | | | | | | | | | | | | and menner as stated. |
| HOSPITAL FUNERAL WITHIN 72 | S | | / | | 1 | | | .,, | -p.nert | | | | protes, at | | | |
| TO THE HOSPIT TO THE FUNERA De filed within 7 | O BE | 29b. SIGNATURE AND TITLE | L H | They | 1 |) | | | | 29c. LIC | 263 | BER | | | | 26, 1996 |
| | ₹ 2 | 30. NAME AND ADDRESS O | | | | | | | | | | | | | | |
| 1.0 | | /John | H. Weig | pel, M.D. 1 | 20 Hos | pita | al Ros | ad Pr | ince | Frede | rick, | Maryl | and 20 | 578 | | |

32. BEGISTRAR'S SIGNATURE In his Savilson Rardall

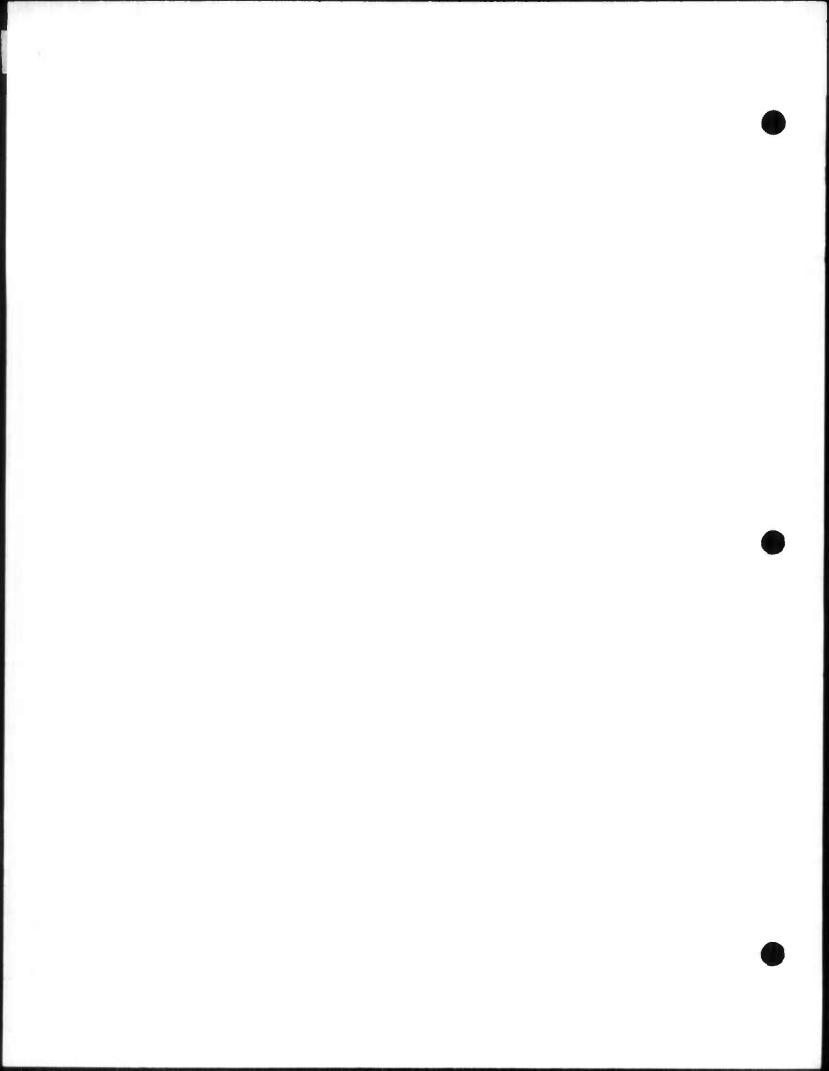
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)

Catherine Jacqueline Miles



LTIMORE, MARYLAND 21215-0020

| BALTIMORE, MARYLAND 21215-0020 | T4 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal. | the medical examiner must be notified at once. |
|---|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68/60 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ref hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be fled within 72 hours after death with the State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | The second secon | garage e | | | | | | | | 91 | 5 0 | 137 | 780 | |
|---------------|--|---|-----------------|------------|-------------|-------------|---|-----------|--|-------------|------------------|-------------------|------------------------------|--|
| | 1 - STATE REGISTRAR | STATE OF MARY | | | | | EALTH AN | D ME | NTAL HYGIEN | E | | | | |
| | 1. DECEDENT'S NAME (First, Middle, List) | | | | | | | | DATE OF DEATH | | | 3. TIME (| OF DEATH | |
| | Wilmer C. McCa | 11, Sr. | | | | | | | anuary 2 | | 996 | 13: | 22 M | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last i | birthday) | IF UNDE | R 1 YEAR | IF UNDER 24 HR | _ | DATE OF BIRTH | 1 1 | | | tete or Foreign | |
| | 215 - 10 - 5988 | 1 M 2 F | 85 | YRS. | MONTHS | DAYS | HOURS MH | | (Month, Day, Year) | Country) | | | | |
| | 90. FACILITY NAME (If not institution, give | street end number) | | | 9h CIT | Y TOWN C | R LOCATION O | | ay 25, 1 | | Mar NTY OF DE | | 10 | |
| E E | Union Hospital | | ntv | | 00.01. | | kton | DEATH | | Sc. 000 | Ceci | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 10b. COUNT | | 7 3 | | | OR LOCAT | | | | | | | | |
| l E | | ecil | - 1 | 10c. CIT | r, IOWN | | rth Eas | n # | | | | 10d, INSI LIMI | TS? | |
| | 10e. STREET AND NUMBER | ecii | | | | _ | ZIP CODE | 5 L | | | | | 8 2 K NO | |
| FUNERAL | 706 Hances Point | Dood | | | | 107 | . ZIP CODE | 010 | 0.1 | | ZEN OF WI | | | |
| = | 11. MARITAL STATUS | | | | | | | 219 | - | | ited | | | |
| B | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 X NO | | 13. | If yes, spe | ENDENT OF HIS scify Cuben, Me 2 X NO Sp | xican, Pr | ORIGIN? (Specify Yes verto Rican, atc.) | or No- | Black, | Mhile, et | | |
| 0 | 15. DECEDENT'S EDU (Specify only highest grad | | | | | CCUPATIO | ON st of working | | 16b. KIND OF BUS | INESS/INC | USTRY | | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Ille. C | Do NOT us | e retired.) | during mos | st or working | | | | | | | |
| I de | 8 | | Self | -emp | oloy | ed c | ontract | or | General | Hau. | ling | & Ex | cavatio | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S | NAME (| First, Middle, Meiden | Sumame) | | | | |
| BE | Walter McCall | | Edna Cameron | | | | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | - | | | | | | | Number, City or Town | | | | | |
| - | Wilmer C. McCall, Jr. 706 Hances Point Road, North East, MD 21901 | | | | | | | | | | | | | |
| | 1 Removal from State Secretary Secret | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY. CROUCH FUNERAL HOME | | | | | | | | | | | | | |
| | 127 South Main Street, North East, | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest | | | | | | | | | | | | | |
| | snock, or heart tellura. List only one cause on each line. | | | | | | | | | | | | | |
| | immediate cause (Final disease or condition resulting in death) | a. Caca Le DUE TO (OR AS | A CONSECU | O COL | 10 | lias | I not. | nnc | how | | | One | set and Death | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING | bDUE TO (OR AS | A CONSEOU | JENCE OF |): | | | | | | | | | |
| H | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQU | JENCE OF |): | | | | | | | - | | |
| F | resulting in death) LAST | 4 | | | | | | | | | | 1 | | |
| ᄬ | | u | | | | | | | | | | + | | |
| MEDICAL | PART II. Other algnificant condition | na contributing to death i | but not rai | aulting i | n the u | ndarlying | cause given | in Pari | I. 24a. WAS AN PERFOR | | | | TOPSY FINDINGS E PRIOR TO | |
| | | | | | | | | | 1 - YES 2 | NO NO | | | ON OF CAUSE | |
| ME | | | | | | | | | | | | | 2 NO | |
| | DID TOBACCO USE CONT | RIBUTE TO CAUSE C | OF DEAT | H YE | s 🗹 | NO 🗆 | UNCERT | AIN [|] | | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSBIYAL | 26. PLACE | OF DEAT | | | | | | | | | | |
| Š | 1 TYES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Out | patient 3 | DOA | OTHE | | 5 🗆 Rasiden | ce 8 🗆 | Other (Specify) | | | | | |
| Y PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WOR | | | | | RK? | 280 | I. DEȘCRIBE HOW II | JURY OCC | CURED | | | |
| COMPLETED BY | 2 Accident Investigation 3 Sulcide 8 Could not be 4 Homicide determined | 28a. PLACE OF INJUR building, etc. (Spe | Y — At home | e, ferm, s | treet, fac | | | 281 | . LOCATION (Street e City or Town, State) | nd Number | or Rural Ro | ute Numb | Φ(, | |
| PLE | 29a. CERTIFIER 1) CERTIFYING PHYS | ICIAN: To the best of my know | vledge, desti | h occurre | d at the | time, date | end place, and | dua to th | ne cause(e) end man | ner ee elet | ed. | | | |
| N | | ER: On the basie of axamination | | | | | | | | | | end menr | ner ee stated. | |
| 1 1 | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | | 29c. LICENSE | | | | | | | |
| BE | Q 2 | Y | | | | | | | | D | E SIGNED (| | | |
| 12 | D 32395 Jan 22, 1996 | | | | | | | | | | | | | |

(Thomas E. Finucan m.D.)

3 Mauldin Avenue,
31. DATE FILED (Month, Day, Year)

JAN 24. 1996

North East MD

32. REGISTRAR'S SIGNATURE

21901

| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| | death. | funer | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | жэш | ı |
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#1 and Amended #6, 1/26/96, P.H., Cecil County

| | #1 and Amended #6, 1/26/96, P | H . Cec | il Count | 3.7 | | | | 96 | 5 6 | 378 | 1 |
|---|--|--|--|--------------------------------|--|-------------------------------|------------------------------|------------|------------------------|---|-------------------|
| | | OF MARYLAN | ID / DEPART | MENT OF I | | | | | | 7070 | • |
| | 4 05050505050 11445 55 14 14 14 14 14 | sther San | a Miller | | DEATH | 2. DATE OF MONTH | OEATH DAY | | YEAR | TIME OF DEA | TH P M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 22 1 - 16-5208 1 □ M 2 | ØF 86 \frac{7}{8} | YRS. | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF Month, D Aag | BIRTH By, Yber) | 8 | . BIRTHPL. Country) | ACE (State or F | |
| TOR | 98. FACILITY NAME (If not institution, give atreet and num Lauvel wood Navs? RESIDENCE OF DECEDENT | | ev | | tton | EATH | | 9c. COUNT | Y OF DEAT | | |
| DIRECTOR | Delaware New Castl | e | | TOWN OR LOCA ilmingt | | | | | 100 | d. INSIDE CIT LIMITS? | |
| FUNERAL | 4520 Sandy Drive | | | 10 | 19808 | | | | N OF WHA | T COUNTRY? | |
| BY | 1 Never Married 2 Married FORCE | ECEDENT EVER IN U \$? 1 YES GIVE WAR OR DATE | 2 NO | II yes, sp | ENDENT OF HISPA ecity Cuban, Maxica 2 X NO Special | вп, Puerto Rica | Specify Yes or n, etc.) | r No 14 | Black, W Specify: | American Indinite, etc. | len, |
| COMPLETED | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1 | | Give kind of wor life. Do NOT use Homemake | rk done during mo retired.) | ON st of working | | nd of Busin | | STRY | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) Morris Steelman | | | | 18. MOTHER'S NA Fannie | AME (First, Midd | | rname) | | | |
| 10 | 10m. INFORMANT'S NAME (Type/Print) Florence Juergens | | | | ive, Wil | | | | | | |
| Florence Juergens 4520 Sandy Drive, Wilmington, DE 19808 METHOD OF DISPOSITION DATE Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date Comment Date | | | | | | | | State | | | |
| | Charles F. Mealey, | Jy. #Mod | 784 | Meale P.O. | y Funera Box 2856 | T Home | s ingto | n, DE | 198 | 05 | |
| | 23. PART I. Enter the diseases, or complication ahock, or heart feilure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death) | Major (| n line. | | | | or reapirat | tory arrea | t, | Approxim Interval B Onset and | atween d Daath |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A CO | DNSEOUENCE OF): | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other significant conditions contributions of the private | | not resulting in | | | Lia | PERFORME | ED? | CO OF | RE AUTOPSY F AILABLE PRIOR MPLETION OF DEATH? | CAUSE |
| IAN: | DID TOBACCO USE CONTRIBUTE T 25. WAS CASE REFERRED TO MEDICAL | 26. | PLACE OF DEATH | | UNCERTAI | N 🗆 | | | | | _ |
| 14Sic | | int 2 - ER/Outpatie | mt 3 🗆 DOA 4 | | e 5 🗆 Rasidence | | | | | | |
| 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | |
| - | 3 Suicide 8 Could not be 4 Homicide detarmined | LACE OF INJURY — uilding, etc. (Specify) | At home, farm, stre | et, lectory, offic | | 281. LOCATIO City or R | N (Street and own, State) | Number or | Rural Route | e Number, | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the bed one) 2 MEDICAL EXAMINER: On the bed | | | | | | | | | d manner as s | itated. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER Walloce Chara 30. NAME AND ADDRESS OF PERSON WHO COMPLETI | toin) | MD | rint) | 29c, LICENSE NUI | C. C. | 2 | DATE S Va | IGNED (MC | onth, Day, Year) | 96 |
| | INallace Obe 31. DATE FILED (Morith, Day Year) 32. RE | 1 | n, m | | cecilt. | on, t | nd & | 2/9/ | 3 | | |
| | JAN 26 1996 Ali | Hurlan P. | 111 | | | | | | | | |

OHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

| endeur Iva, | 110D, 1110C | , 1/30/30, | ICI, Howard | |
|--------------|-------------|---------------|----------------|----------------|
| FOR STATE | STA | TE OF MARYLAN | D / DEPARTMENT | MENTAL HYGIENE |

| 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, La | and the same of th | CEF | RTIF | ICATE (| OF D | EAT | Н | A DATE | REG. NO |). | | 3. TIME OF DEATH |
|--|--|--|--------------------|---|----------|------------|---------|------------------|---------------------------------|------------|-------------------|---|
| 1, DECEDERT S NAME (PISt, MIDDIE, LA | | LLIAM MIC | TIAE | T TT | | | | MONTH | ANUAR | AY 25 | YEAR | 7:47 A |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest bi | | IF UNDER 1 YE | AR I | F UNDER : | 24 HRS. | | OF BIRTH | 1 23 | | LACE (State or Foreign |
| none | 1 X M 2 F | , | YRS. | | | ours | sem. | Jan | 24,] | 1996 | Country) | |
| Se. FACILITY NAME (If not institution, gi | ve street and number) | | | 9b. CITY, TO | WN OR I | OCATIO | N OF DE | | | | Mary | |
| | | | | | | | | 24111 | | | | |
| NATIONAL NAVAL | | ENTER | | B | ETH | ESDA | A | _ | | | MONTG | OMERY |
| 10a. STATE M D. 10b. COL | | | | y, town on L | | AND | rews | Air | Force | Ba | | 10d. INSIDE CITY LIMITS? 1 [X YES 2 \(\) NO |
| 100. STREET AND NUMBER 2071 F. Jackson 11. MARITAL STATUS | Road | | | | | 762 | | | | 10g. CIT | | HAT COUNTRY? |
| 3 Widowed 4 Divorced | | T EVER IN U.S. ARME YES 2 X NO AR DR DATES | | If yo | | y Cuber | | in, Puerto F | ? (Specify Ye | s or No | Black, Specify | American Indian, White, atc. |
| 15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12) NONE 17. FATHER'S NAME (First, Middle, Last) | | (Give | kind of o NOT u | USUAL OCCU work done durin sa retired.) | | of working | 7 | | KIND OF BU | | DUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 1 | s. MOTH | ER'S NA | ME (First, A | liddle, Maider | Sumame) | | |
| Paul William Mi | chael | | | 18) | _ | | _ | | Rasbe | | | |
| Paul W. Michael | | | | F. Jac | | | | | | | | 20762 |
| 20e. METHOD OF DISPOSITION | | | | | | _ | | DAT | | _ | - City or Tow | |
| | Burdal 2 Committee 2 Bernard from State | | | | | | | Texas | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE | E LICENSEE A | Morgan | MI | | | | S OF FA | | 711101 | guii | .,/ | TCAGD |
| 1 ///40 | 000 | | | Don | ald | son | Fun | eral | Home | | | ad 20707 |
| 23. PART i. Enter the diseases, | or complications tha | t caused the deat | h. Do | | | | | | | | | Approximate |
| ahock, of head falls. IMMEDIATE CAUSE (Final disease or condition | ire. List only one cau | ese on each lina. | | | | | | | | | | Onset and Death HOURS |
| resulting in death) | en | (OR AS A CONSEQU | | | 1210 | ΓA | | | | | | II ONO |
| _ | | PULMONARY | | | CE | | | | | | | |
| Sequentially list conditions, | | (OR AS A CONSEDU | | | GE_ | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | , | | |
| CAUSE (Disease or injury that initiated events | C. DUE TO | (DR AS A CONSEQU | ENCE C | OF): | | | | | | | | |
| resulting in death) LAST | | | | | | | | | | | | |
| 8 | 0. | | | | | | | | | | | |
| DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH | tions contributing to | death but not rea | uiting | in the unde | riying o | cause (| iven In | Part i. | 24a. WAS A PERFO | RMED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ND 700 4000 1105 00 | NITRIBUITE TO CA | LICE OF DEAT | | FC [] NC | | LINIC | EDTAH | NI EZI | | | | 1 TES 2 THO |
| DID TOBACCO USE CO | | | _ | TH (Check only | | UNC | ERTAI | NA | | | | |
| 25. WAS CASE REFERRED TO MEDICA | HOSPITAL: | | | OTHER: | | | | | | | | |
| 1 VES 2 ND | 1 4 | BER/Outpatient 3 | | 4 🗆 Nursing | | | sidenca | | | | | |
| | 28a. DATE OF (Month, D | Pay, Year) | 28b. TII | JURY | WORK | (? |] ND | 28d. DE | CRIBE HOW | INJURY O | CCURED | |
| 2 Accident Investigat 3 Suicide 5 Could no 4 Homicide determine | 28a. PLACE O building, | OF INJURY — At home arc. (Specify) | e, term, | street, factory. | , office | | F | 281. LOC City | ATION (Street or Town, State | t and Numb | er or Rural R | oute Number, |
| Check only | HYSICIAN: To the best of | | | | | | | | | | | and manner as stated. |
| 201 STORY THE PLANT CENT | 71/2 | . //. | | | 1 | 9c. LICI | NSE NU | MBER | | 29d. D/ | ATE SIGNED | (Month, Day, Year) |
| | DIVIN | Usup | | | | 01 | 01-0 | 14489 | 5 (VA | | 1/26 | 196 |
| 36. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAU | SE OF DEATH (ITEM | 27) (Typ | e, Print) | | NAT | IONA | L NA | VAL M | EDICA | L CEN | ITER |
| BRIAN DARLING | LCDR MC | IISN | | | | BET | IESD | A MD | 2088 | 9-560 | 00 | |
| JAN 3 0 19 | 36 Julia | AR'S SIGNATURE | all | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Ġ., be detached for use as the burial-transit permit. Pages 1, 2, 3 should

5

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|--|--|--|
| 24 hours af | filled in by | he medic | |
| ate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removel. | r traumatic event, ti | |
| death certific | attending plent | iry, or othe | |
| quires that the | n signed by the Health and Mi | ows any inju | |
| he law re- | e has been | m 23 sh | |
| SICIAN: T | certificati | d, or ite | |
| DING PHY | After this death with | market | |
| L OR ATTEN | L DIRECTOR: | item 28 is | |
| TO THE HOSPITAL | TO THE FUNERAL be filed within 72 | IMPORTANT: II | |
| | | | |

| | 1 - STATE OF STATE OF | MARYLAND / DEP | ARTMENT OF I | | | NE | 96 03783 | |
|---|--|---|--|--|---|---------------------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Leet) AN Ge/O | MA | ISINO | | REG. N 2. DATE OF DEATH MONTH TAN 7. DATE OF BIRTH | DAY 199 | 76 2:20 A M | |
| | 4. SOCIAL SECURITY NUMBER 101-10-6253 Security NAME (If not institution, give street end number) | | AGE (In yrs. lest birthdey) FUNDER 1 YEAR FUNDER 24 HRS. MONTHS DAYS HOURS MIN. 9b. CITY, TOWN OR LOCATION OF D | | | 1918 | BIRTNPLACE (State or Foreign Country) New York Y OF DEATH | |
| TOR | Howard County General Hos | spital | Colu | mbia | | How | ard | |
| L DIRECTOR | 10e. STATE 10b. COUNTY Maryland Howard 10e. STREET AND NUMBER | 10c. | Ellicot | | 10g. CITIZE | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | |
| FUNERAL | 10074 Colonial Drive | | | 21042 | | Unit | ed States | |
| ВУ | 1 Never Married 2 Married FORCES? | NT EVER IN U.S. ARMED I YES 2 X NO MAR OR DATES | If yes, sp | CENDENT OF NISPAN Becify Cuban, Mexicar 3 2 NO Specify | | fes or No— 14 | 4. RACE — American Indian, Black, White, etc. Specify: White | |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (Give kind | IT'S USUAL OCCUPATI of work done during mo of use retired.) | ON ost of working | 16b, KIND OF E | USINESS/INDUS | STRY | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 | +) | al Worker | | U.S. | Post | Office | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NAI | ME (First, Middle, Msid | en Sumeme) | | |
| BE | Pasquale Masino | | | | a Petroce | | | |
| 2 | | | ING ADDRESS (Street | | | | | |
| | Mrs. Frances Masino 20e. METHOD OF DISPOSITION M Burlet 2 Cremetion 3 Themoval from State 4 Donetion 5 Other (Specify) | 20b. PLACE AND DA | 74 Colonia ATE OF DISPOSITION (N For other place) Ins Cemeter | ame of | DATE 20c. | LOCATION - CH | ty or Town, State New York | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE The a Call | ins | Harry | ND ADDRESS OF FAC | ke Funera | al Home | | |
| | 23. PART I. Enter the diseases, or complications the shock, or heart feilure. List only one complement of the shock of the | | | | | apiratory arres | Approximate Interval Between Onset and Death | |
| ATION | Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING | nhave | | 8 Days | | | | |
| ERTIFICATION | CAUSE (Disease or Injury | O (OR AS A CONSEQUENCE | DE OF): | AL UL | cen | | 7 19843 | |
| PHYSICIAN: MEDICAL CE | PART II. Other significent conditions contributing to death but not resulting in the underlying course given in Part I. Tenpoint Antenities Confective Heart Fullure DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO NO NORMAL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO Inpatient 2 | | OTHER: | | | | | |
| HYS | 27. MANNER OF DEATH 280. DATE C | FINJURY 286 | TIME OF 28c. IN | uury AT | 28d. DESCRIBE HO | W INJURY OCCU | PRED | |
| 1 Natural 5 Pending (Month, Dey, Year) INJURY WORK? VES 2 TO NO | | | | | | r Rural Route Number, | | |
| E COMPLETE | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of | | | | tima, date end piece, | end due to the | | |
| TO BE | TO MANUATION OF DEDECTION WHO COMPLETED OF | INSE OF DEATH TITEM 27 | (Time Driet) | 0257 | 74 | D.J. | AW 20-96 | |

| 1 Inpatient 2 ER/Outpatient | 3 🗆 DOA |
|---|---------|
| 28e. DATE OF INJURY (Month, Day, Year) | 28b. Ti |

| Suicide 6 Could not be determined | building, yc. (S ₁ |
|-----------------------------------|-------------------------------|
| CENTIFIED | |

| ") | 2 MEDICAL EXAMINER: | On the beste of | examination end/o | or investigation, in my opi | nion, death occured at the time, date | end piece, end due to the ceuse(s |
|---------------|---------------------------|-----------------|-------------------|-----------------------------|---------------------------------------|-----------------------------------|
| - | | | | | | |
| GNMTUN | ME AND THELE OF CERTIFIER | 1 | | | 200 LICENSE MUMBED | 294 DATE SIGNED |

| N. Joleph V | GAGLARD: 150 | 8492 | BALTIMONE NATIL | GIKE | Ellicott city |
|-----------------------------------|---------------------------|------|-----------------|------|---------------|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | Kd |
| JAN 2 2 1996 | Jalin Devoler Revell | | | | 21045 |

| BALTIMORE, MARYLAND 21215-0020 | YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | e medical examiner must be notified at once. |
|---|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68766 | TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| The | 2 | J | |
| | 15 | | |
| Su | - | | |

| STATE OF MARYLAND | / DEPARTMENT | OF HEALTH AND | MENTAL HYGIENE |
|-------------------|--------------|---------------|-----------------------|
| | CERTIFICATE | OF DEATH | REG NO |

| 1 | FOR STATE REGISTRAR | STATE OF MARY! | AND / DEPARTM | ENT OF H | EALTH AND I | MENTAL HYGIENI REG. NO. | | 00104 | | | |
|----------------------|--|---|--|----------------------------|--------------------------|--|---|---|--|--|--|
| 1 | . DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF CEATH DAY | Y YEAF | 3. TIME OF DEATH | | | |
| | SILAS | CONRAD | MILLESON | JR. | | JANUARY 29 | 1996 | 10:00 A " | | | |
| | 234–60–3758 | 4-60-3758 IN IN 2 - F 81 YRS. MONTHS DAYS HOURS MIN. JUMPID DES 191 | | | | | 14 We | est Virginia | | | |
| - 1 | Sacred Heart Ho | | | Cumber | n Location of DE land | ATH | Allega | | | | |
| | 0e. STATE 10b. COUNTY | shire | | own on LOCAT | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | | |
| HAL | P. O. Box 400 | | | 101. | ZIP CODE 26763 | | U.S. | F WHAT COUNTRY? | | | |
| Ξ , | 1. MARITAL STATUS Never Merried 2 X Merried Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR I | 2 X NO | | city Cuben, Mexica | IIC ORIGIN? (Specify Yes n, Puerto Ricen, atc.) | or No — 14. R | ACE — American Indian, lack, White, etc. | | | |
| COMPLETED | 15, DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 12th | CATION completed) College (1-4 or 5+) | 16e. DECEDENT'S USU (Give kind of work life. Do NOT use re Farmer | done during mos tired.) | N st of working | 166. KIND OF BUS | | | | | |
| | 7. FATHER'S NAME (First, Middle, Last) Silas C. Mi | lleson Sr. | | | | ME (First, Middle, Malden : Susan Fre | | | | | |
| IO BE | 90. INFORMANT'S NAME (Type/Print) Nannette E. Mil | | | | | Route Number, City or Town | , State, Zip Code) | | | | |
| | 20a. METHOD OF DISPOSITION 1 | | | | | | | | | | |
| | 230 East Main St., Romney, WV 26757 23. PART I. Enter the diseases, or compiler into the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the caused the cause on each line. | | | | | | | | | | |
| - 11 | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Consession Frank | | | | | | | | | | |
| FICAL | disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Long estime (Frank Fai u y) Over 10 (or As A consequence of): (Over 10 (or As A consequence of): Due TO (or As A consequence of): Due TO (or As A consequence of): Due TO (or As A consequence of): | | | | | | | | | | |
| PHTSICIAN: MEDICAL C | PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algorification conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part II. Other algorification in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 | | | | | | | | | | |
| KING P | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | e 5 🗆 Reeldence | 6 Other (Specify) | | | | | |
| | 1. MANNER OF DEATH 1. Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 26c. INJ | URY AT | 26d. DESCRIBE HOW II | NJURY OCCURED | | | | |
| ED BY | 2 Accident Investigation | | | | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| COMPLE | and the same of th | CIAN: To the best of my kno | | | | | | se(e) end manner ee stated. | | | |
| S E | 196. SIGNATURE AND TITLE OF CERTIFIER | 100 | .//. | | 29c. LICENSE NUI | | | NED (Month, Day, Year) | | | |
| ا ا | 10. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF B | EATH (ITEM 27) (Type, Pri | nt) | | Cumberland MID ZI | | | | | |
| 3 | N. DATE FILED (MONTH, Day, Year) FEB 0 2 1996 | THE REGISTRAR'S SIG | | Sela | n Dr- C | umberla | nd " | 11D 21502 | | | |

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

| D | HOSPITAL OR | FUNERAL DIR | within 72 hour |
|----|-------------|-------------|----------------|
| | 품 | 뿓 | filed |
| 8 | 2 | 2 | Pe |
| 14 | >< | S | |

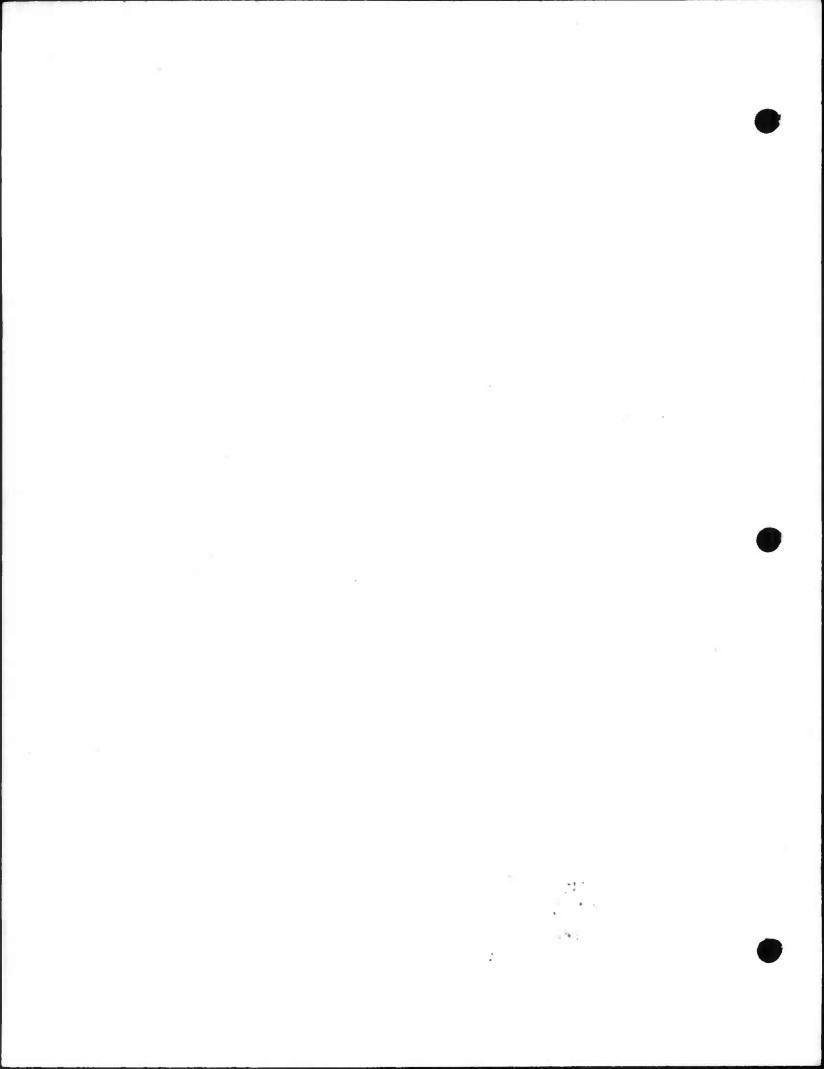
SATURNIA C

31. DATE FILED (Month, Dey, Vest)
FEB 01 1996

| | | | | ERTIFI | CATE | OF | DEATH | | REG. NO |). | | | |
|-------------|---|---------------------------|---|------------------------------------|---|----------|-----------------------------|---|----------------------------------|-----------|-----------|------------------------|---------|
| 1 7 | 1. DECEDENT'S NAME (First, Middle, Last) KATHERINE SARAH MINNICKS | | | | | | | | 2. DATE OF DEATH DAY YEAR 3. TIN | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Is | nat historia d | IF UNDER 1 | vean I | F. 101000 04400 | JAN. | 28 | , 199 | | 9:40 | P |
| | 214 07 4422 | 1 □ M 2 ဩ F | 86 | | | DAYS | IF UNDER 24 HRS. HOURS MIN. | | Day, Year) | | Count | | Foreign |
| | 9e. FACILITY NAME (If not institution, give | | | 10000 | Oh CITY | TOWN O | R LOCATION OF D | | 17, 1 | | MAR | YLAND | |
| DIRECTOR | ST. VINCENT de P | | ING HOME | | | | TBURG | EATH | | | LEGA | | |
| E I | 100. STATE 10b. COUNT | Υ | | 10c. CITY, | , TOWN OR | LOCATI | ION | | | | | 10d, INSIDE C | TY |
| 100 | MARYLAND AL | LEGANY | | | FRO | STRI | IIRG | | | | | LIMITS? | □ NO |
| A | 10e. STREET AND NUMBER | | | | | 100 | ZIP CODE | | | 10g. CIT | IZEN OF V | WHAT COUNTRY | |
| FUNERAL | 100 HONEYSUCKLE | | | | 1 2 | 21532 | | | 11 | .S.A | | | |
| 5 | 11. MARITAL STATUS | | T EVER IN U.S. A | | 13. W | AS DECE | ENDENT OF NISPA | NIC ORIGIN | (Specify Ye | | 14. RACI | E — American In | dien, |
| BY F | 1 Never Married 2 Merried FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DA | | | Z _{MO} | | | 2X NO Specific | | Ican, etc.) | | Spec | k, White, etc. lly: | |
| | 21 | | | | | | | | | | WHITE | | |
| ETED | (Specify only highest grade completed) | | | Give kind of wo | ECEDENT'S USUAL OCCUPATION Bive kind of work done during most of working | | | | KIND OF BU | SINESS/IN | DUSTRY | | |
| 7 | College (1-4 or 5 +) | | | | CCRETARY | | | | CELAN | ESE | CORP | | |
| COMPL | 17. FATNER'S NAME (First, Middle, Last) | | | | | | | | | - | | | |
| E C | FRAN | | 18. MOTNER'S NAME (First, Middle, Melden Surname) | | | | | | | | | | |
| 00 | 19e. INFORMANT'S NAME (Type/Print) | 9b. MAILING | NETTIE MYERS ING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) | | | | | | | | | | |
| 2 | PAUL MYERS 23 HIGH STREET, FROSTBURG, MD 21532 | | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION | | | | | | | | | | | | |
| | Cemetery or other place Commetter Commetter Commetter Commetter | | | | | | | | | | | | |
| | 21. SIGNATURE OF TUNEVAL SERVICE DECEMBER 22. NAME AND ADDRESS OF FACILITY SOWERS FUNERAL HOME, P.A. | | | | | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | |
| | snock, or heart failure. List only one cause on sech lins. | | | | | | | | | | Betwee | | |
| | iMMEDIATE CAUSE (Final disease or condition | DIAC | DysRHymIhmis | | | | | | | | Proof a | 10 Deal | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | DUI | | |
| z | | | | | | | | | | | | out | |
| 유 | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | 1111 | , | |
| ₫ | Cause. Enter UNDERLYING CAUSE (Disease or injury C. CORONARY ARTERY DISEASE | | | | | | | | | Unk | Au | | |
| RTIFICATION | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | | | |
| SER | d | | | | | | | | | | | | |
| - H | PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | | |
| MEDICAL | URGANIC | - BRA | IN SI | YNDR | MOS | E | | | PERFO | | | AVAILABLE PRIC | |
| | J | | 1 | | | | | _ | 1 TYES 2 | IN NO | | DF DEATH? | 1 110 |
| | DID TOBACCO USE CONT | RIBUTE TO CA | USE OF DEA | ATH YES | S \square N | 0 12 | UNCERTAIL | | | | | 1 YES 2 | NO |
| Į. | 25. WAS CASE REFERRED TO MEDICAL | | | CE OF DEATH | | | OTTOERINI | 101 | | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 | ER/Oulpatient 3 | | OTHER: | | 5 Residence | 6 COther | (Specific) | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 25e. DATE OF (Month, D | INJURY | 28b. TIME | OF 2 | 8c. INJU | JRY AT | | RIBE HOW I | NJURY OC | CURED | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (MORH, C | ay, rour) | INJU | M | | WORK? | | | | | | |
| 8 | 3 Suicide 6 Could not be determined | 26e. PLACE O building, | F INJURY — At he etc. (Specify) | ome, ferm, str | me, ferm, street, factory, office | | | 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) | | | | Route Number, | |
| Ē | 290. CERTIFIER 1 CERTIFYING PHYS | CIAN. To the best of | | | | | | | | | | | |
| COMPL | (Check only one) 2 MEDICAL EXAMINE | CIAN: To the best of | | | | | | | | | | and more | -1-1 |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | yanon, | , at my ope | | | | unz piace, en | | | | |
| H | Source and Title OF CERTIFIES | 2111 | 0 | | | | 29c. LICENSE NUI | ABER つ <i>つ</i> | | 29d. DAT | E SIGNED | (Month, Day, Yea | 1 |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | X | - | 5. Cherry 10 D 256 38 Jan. 29 1996 | | | | | | | | | 160 |

COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
ANG, Rt 36 Frustleung)

A. REGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O.

| | FOR_ | STATE OF | MARYI AND | DEPAR | ITMENT | r OF H | FAITH AND | MENTAL HYGIEN | IF. | 96 | 031 | 86 | | |
|---------------|--|--------------------|---|-----------------------------|---------------------------|-------------|--------------------------|--|-----------|-------------|---|---------|--|--|
| | STATE REGISTRAR DECEDENT'S NAME (First, Middle, Last) | - OINIE OI I | | | | | DEATH | REG. NO | | | 3. TIME OF DEA | тн | | |
| | George Albert | | Markwood | 1 | | | | January 29 | 1 0 | YEAR | 8:15 | А м | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. la | at histoday | IF UNDER | A WEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 7, 13 | y | HPLACE (State or Fi | | | |
| - 1 | 0 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0 | 1 M 2 F | | YRS. | MONTHS | DAYS | HOURS MIN. | (Month, Day, Year) | | Count | try) | ureign | | |
| | 213-10-7049 | | 94 | ing. | | | | March 2, | | | | | | |
| ~ | Se. FACILITY NAME (If not Institution, give st | | | | | | R LOCATION OF D | EATH | | UNTY OF E | | | | |
| 6 | Devlin Manor Nur | sing Hor | 1e | | Cun | ber1 | and . | | A1: | legar | ny | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN (| OR LOCAT | ION | | | | 10d. INSIDE CITY | | | |
| | Maryland Alleg | ;any | | Cun | ber1 | and | | | | | 1 🗶 YES 2 🗌 | NO | | |
| A | 10e. STREET AND NUMBER | | | | | 101 | ZIP CODE | | 10g, Cl | TIZEN OF | WHAT COUNTRY? | | | |
| H | 715 Glenmore Stre | et | | | | | 21502 | | U.S. | . A. | | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced | FORCES? | NT EVER IN U.S. AI 1 YES 2 X WAR OR DATES | | | If yes, spi | | NIC ORIGIN? (Specify Yee or No— 14. RAC an, Puerto Rican, etc.) | | | CE — American Indian, lok, White, etc. | | | |
| 8 | 15. DECEDENT'S EDUC | CATION | | ECEDENT'S | | | | 16b. KIND OF BU | SINESS/IN | IDUSTRY | | | | |
| | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 | 105 | Bive kind of B. Do NOT u | work done se retired.) | during mo | st of working | | | | | - 3 | | |
| COMPLET | 6 | College (1-4 of 5 | | us Dr | iver | | | Trans | norts | ation | | | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTHER'S NA | ME (First, Middle, Meiden | | | | | | |
| | William | Markw | hood | | | | | | 1200 | | | | | |
| BE | 19e, INFORMANT'S NAME (Type/Print) | Halkw | | AL MAILING | Anness | g /Stmal a | Margaret Louella Rodgers | | | | | | | |
| 2 | Florence Markwood | | 1 | | | | | | | | 1 01 50 | | | |
| | 713 Glemmore Bereet, Gumberland, Maryland 21302 | | | | | | | | | | | | | |
| | 20b. PLACE AND DATE Of DISPOSITION 1 X Burlel 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) Sunset Memorial Park January 3, 1,1996 Cumberland, Maryland | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 3. 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | |
| | Merritt-Adams | | | | | | | | | 1 1 | 2150 | 2 | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate | | | | | | | | | | | | | |
| | ahock, or heart fallure. List only one cause on each line. | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | | | | |
| | disease or condition resulting in death) s. Promu (a 3 | | | | | | | | | | | celu | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| Z | disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Co cross of the property of the conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | | | | |
| 2 | CAUSE (Disease or injury | C | De | luga | the | 100 | | | | | 200 | rug | | |
| E | that initiated events | DUE TO | OR AS A COMSE | COUENCE O | F): | | | | | | | | | |
| E | resulting in death) LAST | d | | | | | | | | | | | | |
| · . | PART ii. Other aignificant condition | as contributing to | n death but not | regulting | In the w | nderlyln | n cause alven in | Part I. 24s. WAS AN | ALITTODOS | 7 7 24 | - WEDE ALITOREY I | EMPINOS | | |
| MEDICAL | TANT II. Other aigniticant condition | a continuenting to | o death but not | resulting | III the di | detrym | g cause given in | PERFO | | - 24 | b. WERE AUTOPSY I | OT F | | |
| ă | | | | _ | | | | 1 YES | 2 NO | | OF DEATH? | CAUSE | | |
| ME | | | | | | | | _/ | | | 1 TES 2 | NO | | |
| ż | DID TOBACCO USE CONT | RIBUTE TO CA | AUSE OF DEA | ATH Y | ES 🗀 | NO [| UNCERTAI | N/O | | | | | | |
| ZIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLA | CE OF DE/ | | | | | | | | | | |
| Sic | 1 ☐ YES 2 🛣 NO | HOSPITAL: | ☐ ER/Outpatient | 3 🗆 DOA | OTHE 4文 Nu | | e 5 🗆 Reeldence | 6 Other (Specify) | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE O | | 28b. Til | | 28c. INJ | | 28d. DESCRIBE HOW | INJURY O | CCURED | • | | | |
| | 1 Nstural 5 Pending | (Month, | Day, Year) | l IN | JURY | | PK? | | | | | | | |
| В | 2 Accident Investigation 3 Suicide & Could not be | 26e. PLACE | OF INJURY — At h | ome, ferm, | atreet, lec | tory, offic | • | 28f. LOCATION (Street | end Numb | er or Rural | Route Number, | | | |
| | 4 Homicide 6 Could not be determined | building | , etc. (Specify) | - | 7 | | | City or Town, State | | | | | | |
| E | 29e. CERTIFIER A NO CERTIFICATION OF THE PROPERTY OF THE PROPE | - | | 7 | / | | | | | | | | | |
| API | (Check only | _ / | 2 | / / | | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINE | R: On the basis of | examination and/or | Myoatlasti | on, in my | opinion, d | eath occured at the | time, date end place, e | nd due 10 | the counci | (e) end menner ee | stated. | | |
| EC | 29b. SIGNATURE AND TITLE OF CERTIFIE | 9 // | 1/1/ | | | | 29c. LICENSE NU | MBER | 29d. D/ | ATE SIGNE | D (Month, Day, Year |) | | |
| 00 | / | 1.1 mg | 10/ | | | | D-3676 | 6 | ▶.I. | anua | ry 29, 1 | 996 | | |
| 2 | 30NAME AND ADDRESS OF PERSON WH | O COMPLETED CA | ISE OF DEATH (IT | FM 27) /5m | n (Print) | | 2 3070 | | | | -, -, - | 2.0 | | |

29d. DATE SIGNED (Month, Day, Year) ▶ January 29, 1996 D-36766 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Vikramaditya Poonai, M.D. 955 Frederick Street, Cumberland, Maryland 21502

31. DATE FILED (Modified Property Street) 32. Distracts Signature 31. DATE FILED (Month Dog)

1 . 7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

| | | | | State of M | aryland / | - | | | lealth an Death | | Reg | ene g | 16 | 03787 |
|-------------|--|---|--|--|--|-------------|----------------------|--|--------------------------|--------------------------|---|----------------|------------------------------|---|
| | Physici /Medic | | | stine M | lason | | | | | 2. Dete Monti Jani | lary | | 1996 | 3. Time of Death 9:10PM |
| 7 | Examir | ner | 4a. Fecility Neme (If not institution, giv Washington Cou | the second secon | | | | 4 | На | or Location of | own | | of Death hing | ton |
| | Funerai Director | | 5. Sociel Security Number 234-38-7697 Usual Residence of Decedent | ex 7. Ag □M 2∑7 F | ge (In yrs. lest b | | If Under 1 Months | 1 Yeer Deys | if Under 24 I Hours N | Ain. 8 Date (Mont) | Birth Y | 30 | 9. Birthpl Count W • V | lece (State or Foreign try) irginia |
| | e Meryland la-f show tyled at | ctor | 10e. Stete 10b. County | ngton | 10c. City, Too | | | | | | | | 10 | 0d. inside City Limits 1 ⊠ Yes 2 □ No |
| | 23a or 24 | rai Director | 10e. Street end Number 25 1/2 West F | ranklin' | St. # | | 10f. Zip (| Code 74 | 0 | | 10g. Citizen of Whet C | | | ry? |
| 020 | n 72 hours after death with the Meryland "natural", or flems 23a or 28a-f show potent Evanther must be notified at | by Funeral | 11. Maritel Stetus 1 □ Never Merried 2 ☑ Merried 3 □ Widowed 4 □ Divorced | Armed Forces? | 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes | | | edent of Hispanic Origin? (Specify Yes or pecify Cuben, Mexican, Puerto Ricen, etc.) 2℃No Specify: | | | (se or No- , etc.) 14. Rece - American in Black, White, etc. Specify: Blac | | | etc. |
| 21215-0020 | within ene. than " | Completed | 15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12) 1 2 | de completed) | ucetion de completed) College (1-4or 5+) 16e. Decedent's Usi (Give kind of w life. DO NOT Housev | | | suel Occupetion work done during most of working use retired) Wife | | | 18b. Kind of Business Homemake | | | ustry |
| Maryland | be de la | To Be C | 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumemi | | | | | | | | | | | |
| | nd 2 sh alth and 27 is m r traum | | 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route 626 N. Mulberry St. Ha | | | | | | | St. Ha | Hagerstown, MD 21740 | | | |
| Baltimore, | 8 7 | | 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery) 20b. Place of Disposition (Neme of cemetery) 20b. Place of Dispositio | | | | | | | | | | | |
| Bal | permit. Pag Department Important: any Injury o | | 21. Signeture of Funderel Service Licer | - Walts | / | 24 | W.I | Bet | | .Hage | rsto | | | 740 |
| | Physician | | 23a. Pert1. Enter the diseese, or com shock, or heert tailure. List only | one ceuse on eech li | ine. | | | | | | | | | Approximete Intervel Between Onset end Deeth |
| | /Medical Examiner | | immediete Cause (Finel diseese or condition resulting in deeth) | · Disse | Min a Due to (or es e | ted | In 7 | rav | ascul | an Col | agul | ater | 1 | 8 hours |
| | od dansit | Examiner | Sequentially ites conditions | b. E. C | | conseque | ais | | | | | | | |
| 68760, | cate be executed oblysician and the burial-transit | cai | Ceuse (Disease or Injury that initiated events | | | | | | | | | | | |
| Вох 6 | eath certificate attending phys I for use as the | an/Me | C | d. Deli | ydro | x te | on | | | | | | | |
| P.O. | that the ded by the | y Physician/Medi | Pert II. Other significant conditions of | ontributing to death b | out not resulting | in the unde | erlying ce | ouse giv | en in Pert I. | 23b. | | 2 No | | the cause of death? |
| Records, | aw requir | Completed by | | | | | | | | 24e. | Wes en performe | eutopsy od? | cor | ere eutopsy tindings bileble prior to apletion of ceuse deeth? |
| a B | The ate h | | | | | | | | | | | 2 🗆 No | 1 🗆 | Yes 2□ No |
| Vital | Physician: this certific ral director, | o Be | 25. Wes case referred to medical exeminer? 1 Yes 2 No | Hospitel: | ent 2 ER/C | Outpetient | 3 DO/ | A Oth | OF: | Deeth (Check | | ce 8 □Oth | ner (Specify | () |
| Division of | ling Ph | Tayling attention 2 Larvourpellerit 3 Look 4 Livering from 5 Livering | | | | | | | | | | | | |
| Divi | 크를 | i Certification: | 3 Suicide 6 Could not b determined | building, el | ury - At home, to. (Specify) | | | | | City | or Town, | Stete) | | I Route Number, |
| | the Hospital thin 24 hours of the Funeral mpletely filled | Medicai | | ysician: To the best niner: On the basis of end menner st | t exeminetion e | | stigation, | in my o | | | time, dete | | and due to | the cause(s) |

Cd Division of Vital Records. To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by

29b. Signeture end title of certitier

29c. License number

29d. Dete signed (Month, Day, Year)

D09083

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PASCUAL PASCUA PATALINGHUG- 138 E. ANTIETAM ST. HAGERSTOWN, MD. 21740

State Registrar

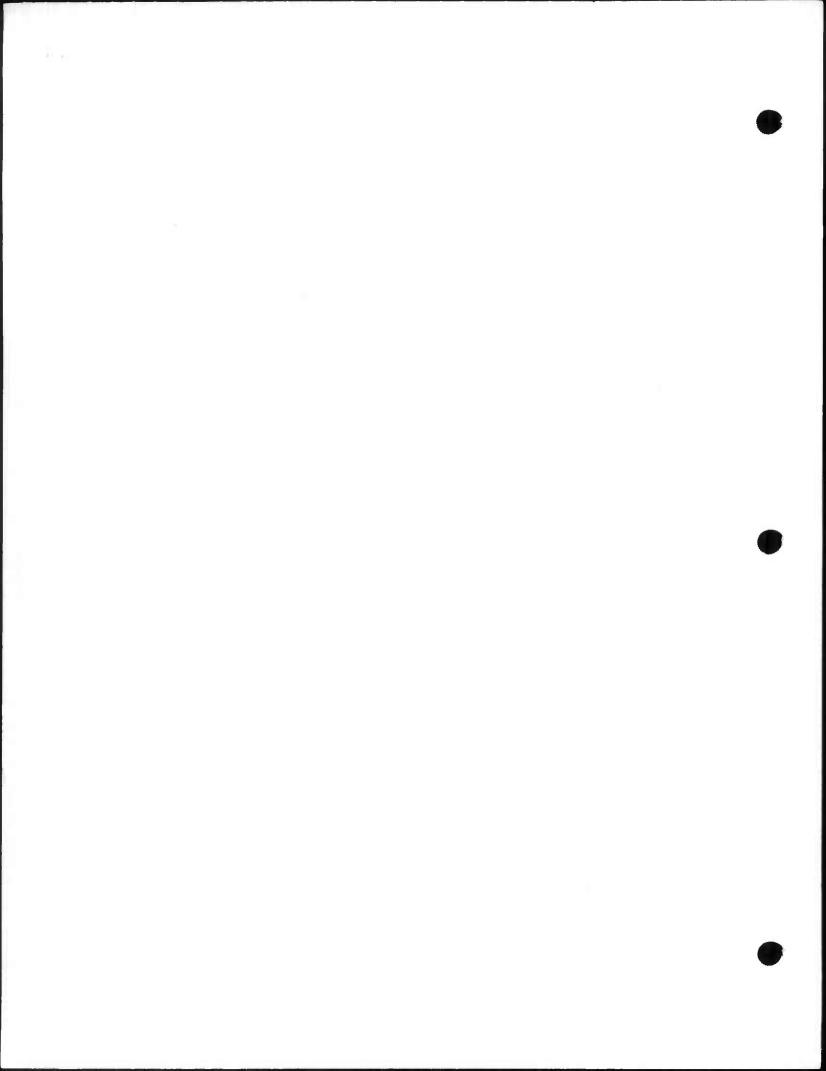
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - REGISTRAR | CERTIF | ICATE OF | DEATH | REG. NO | D. | | | | | | | | | | | |
|---------------|--|---|------------------------------------|----------------------|--------------------------|-------------|--|---|--------|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | | | | | | |
| | LOIS MYRTLE | MO | ORES | | | 30 | 96 | 12:20 | AM | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7 0475 05 05000 | | | LACE (State or Foreign | AM | | | | | | | | |
| | 213-58-4336 1 M 2 XF 93 | YRS. | MONTHS DAYS | HOURS MIN. | AUG. 2, 1 | 902 | Country) | YLAND | ,,, | | | | | | | | |
| | 9e. FACILITY NAME (if not institution, give street end number) | | Sh CITY TOWN | OR LOCATION OF D | | | | | | | | | | | | | |
| DIRECTOR | #9 SHANNON TERRACE | | | | EAIN | | NTY OF DEA | | | | | | | | | | |
| | RESIDENCE OF DECEDENT | | EA | STON | | TA | ALBO' | <u>r</u> | | | | | | | | | |
| Ĕ. | 10e. STATE 10b. COUNTY | 10c. CIT | Y, TOWN OR LOC | TION | | | Ti | IOd. INSIDE CITY | - | | | | | | | | |
| 능 | MARYLAND TALBOT | | EASTON | | | | - 1 | LIMITS? | | | | | | | | | |
| 7 | 10e. STREET AND NUMBER | | | of, ZIP CODE | | 10a CITI | | AT COUNTRY? | | | | | | | | | |
| 3 | #9 SHANNON TERRACE | | - 1 | 21601 | | log. c. i. | | | | | | | | | | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U | S ADMED | 12 WM C DG | | NIC ORIGIN? (Specify Y | | USZ | | | | | | | | | | |
| | 1 Never Married 2 Married FORCES? 1 YES | 2X NO | If yes, s | pecify Cuben, Mexico | in, Puerto Rican, etc.) | e or No- | Black, | - American Indien, White, etc. | | | | | | | | | |
| 8 | 3 Wildowed 4 Divorced | :5 | 1 L YE | S 2 XNO Specif | y: | - 1 | Specify: | WHITE | | | | | | | | | |
| | 15. DECEDENT'S EDUCATION 16 | Ba. DECEDENT'S | USUAL OCCUPAT | ION | 16b. KIND OF BU | JSINESS/IND | USTRY | *************************************** | | | | | | | | | |
| ᇤ | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | (Give kind of a | work done during n se retired.) | ost of working | | | | | - 1 | | | | | | | | |
| 릴 | 12 3 | REGTS | TERED | NURSE | N | URSIN | VC. | | | | | | | | | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | ME (First, Middle, Meide | | 10 | | _ | | | | | | | | |
| BE C | THOMAS SHREVE MARVEL | | | | BETH A. | | AT. | | | | | | | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILING | ADDRESS (Street | | Route Number, City or To | | | | _ | | | | | | | | |
| 2 | JOHN D. MOORES | #9 9 | наммом | TEDDAC | E, EASTO | м мт | 214 | 501 | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 20b. Pl | | OF DISPOSITION (A | | | OCATION — | | | | | | | | | | | |
| | 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | PRTNC | ther place) | PMETEDV | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | | | | |
| | NEWNAM FUNERAL HOME, P.A. | | | | | | | | | | | | | | | | |
| | YOHN R. MERLERON | CFSP | 200 | S. HAR | RISON ST | . , EZ | ASTO | MD . | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused it shock, or hasnt failure. List only one cause on each | he desth. Do r h line. | not enter the m | ode of dying, suc | h ss cardiac or reep | piratory sm | est, | Approximate interval Between | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | - | 11 | , / | | | | Onset and De | | | | | | | | | |
| | disease or condition a. | un | Der | 1 for | lin | | | 3 700 | 3 | | | | | | | | |
| | DUE TO (OFFICE A CO | ONSEQUENCE OF | F): | 0 | | | | | | | | | | | | | |
| 8 | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | MSECUENCE OF | ·): | | | | | | - 1 | | | | | | | | |
| 윤미 | CAUSE (Disease or Injury C. | ONSEQUENCE OF | n. | | | | | + | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | SHOLO DENOL OF | 1. | | | | | İ | - 1 | | | | | | | | |
| S | d | | | | | | | İ | _ | | | | | | | | |
| | PART II. Other significant conditions contributing to deeth but | not resulting l | n the underlyle | g ceuse given in | | | | ERE AUTOPSY FINDIN | NGS | | | | | | | | |
| DICAL | | | | | PERFO | RMED? | C | VAILABLE PRIOR TO OMPLETION OF CAUS | E | | | | | | | | |
| MED | | | | | I U YES | 12.40 | | F DEATH? | | | | | | | | | |
| - | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | DEATH YE | S EL NO E | LINCEPTAIL | u m | | Ι, | YES 2 NO | - 1 | | | | | | | | |
| ₹ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetle | 2 DOA | OTHER: | | | | - | | | | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 280. DATE OF INJURY | 28b. TIM | | JURY AT | 28d. DESCRIBE HOW | IN HIRY OCC | HIBED | | -1 | | | | | | | | |
| | 1 Natural 5 Pending (Month, Day, Year) | INJ | URY W | YES 2 NO | and. Describe now | INJUNI OCC | ONED | | - 1 | | | | | | | | |
| BY | 2 Accident Investigation 3 Suicide S Could set by 28e. PLACE OF INJURY — | Al home form a | | | 281, LOCATION (Street | and Mumber | O (O | to Museline | - | | | | | | | | |
| | Suicide Could not be building, etc. (Specify) Nomicide | , | ,,, | ~ | City or Town, State | | or nurer nou | NO PORTION, | - 1 | | | | | | | | |
| | 29e. CERTIFIER | | | | | | | | - | | | | | | | | |
| M M | (Check only CERTIFYING PHYSICIAN: To the beat of my knowledge | | | | | | | | _ | | | | | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end menner as stated. | | | | | | | | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CENTIFIER | / | 4 | 29c. LICENSE NUM | | | | fonth, Day, Year) | \neg | | | | | | | | |
| 10 | stephin . an | nger | | 20 | 1225 | - 1 | -30 | -96 | | | | | | | | | |
| - | 30. NAME AND ADDRUGE OF PERSON WHO COMPLETED CAUSE OF DEATH | (ITI)® \$77 (Types | Print) | | | | | | \neg | | | | | | | | |
| | STEPHEN P. CARNEY, M.D., 509 IDLEWILD AVE., EASTON, MD 21601 | | | | | | | | | | | | | | | | |
| | STEPHEN P. CARNEY, M.D. | , 509 | TOTEM: | LLD AVE. | . EASTO | M, MD | 31. DATE FILED (Month, Day, Year) 2. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| | | IRE | TDTEM. | LLD AVE | , EASTO | N, ME | 216 | 501 | - | | | | | | | | |



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
|---|--|--|-------------------------|--------------------------------|---------------------|---|-----------------|----------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | | |
| | Doris Margaret | | | | | | 20, 19 | 96 | 12:00 p M | | | |
| | | | (In yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | - 1 | . BIRTHP Country) | LACE (State or Foreign | | | |
| | 215-20-1611 9e. FACILITY NAME (If not institution, give stree | 1 □ M 2 😾 F | 73 YRS. | | | Dec. 24, | 1922 | | | | | |
| œ | | it end number) | | | OR LOCATION OF D | DEATH | 9c. COUNT | | | | | |
| DIRECTOR | 701 Race Street | | | Cambrio | lge | | Dorc | hest | er | | | |
| RE(| 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOCA | TION | | | | 10d, INSIDE CITY | | | |
| | | nester | Can | bridge | | | | | YES 2 NO | | | |
| RAL | 10e. STREET AND NUMBER | | | 10 | f. ZIP CODE | | 10g. CITIZE | N OF W | AT COUNTRY? | | | |
| FUNERAL | 701 Race Street | 2. WAS DECEDENT EVER I | | | 21613 | | USA | | | | | |
| | 1 Never Married 2 Merried | FORCES? 1 YES | 2 TNO | If yes, st | pecify Cuben, Mexic | ANIC ORIGIN? (Specify Yean, Puerto Rican, etc.) | es or No- 1 | Black, | - American Indian, White, stc. | | | |
| ВУ | 3 Widowed 4 Divorced | IF TES, GIVE WAN ON D | ATES | 1 TYES | 3 2 X NO Spec | ffy: | | Specify | Black | | | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade co. | TION mpleted) | 16a. DECEDENT'S | USUAL OCCUPATE | ON of working | 16b, KIND OF B | USINESS/INDU | STRY | | | | |
| 37 | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | e retired.) | _ | | | | | | | |
| MP | 11th 17. FATHER'S NAME (First, Middle, Leet) | | Food Ser | vice Sp | 1 | | | | | | | |
| | Robert Sampson | | | | | AME (First, Middle, Melde | n Sumame) | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | | Stanley Route Number, City or To | wa State 7in C | orde1 | | | | |
| 6 | Tonya Cornish | | | | | way, Cambi | | | 21613 | | | |
| | 20e. METHOD OF DISPOSITION 1 Description 2 Cremetion 3 Remove | | PLACEANDDATE | OF DISPOSITION (N | | DATE 20c. L | | | | | | |
| | 4 Donation 5 Other (Specify) | | Bethel Co | emetery | | 1/26/96 | Camb | ridg | e, Md. | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Services | | | | | | | | | | | |
| | P.O. Box 1687, Easton, Md. 21601 | | | | | | | | | | | |
| | 23. PART i. Enter the diseesea, or con ahock, or heart failure. Lis | nplications that cause | d the death. Do n | ot enter the mo | ode of dying, au | ch as cardiac or rea | piratory arres | ot, | Approximata Interval Between | | | |
| | ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final | | | | | | | | | | | |
| | disease or condition resulting in death) | COUGEST | TIVE . | WEDR7 | F | AICURE | | | 1 YEAR | | | |
| | | HYPERTE | CONSEQUENCE OF | 7): / | | | | | LIEMS 5 | | | |
| O. | Sequentially list conditions, if any, leading to immediate | | CONSEQUENCE OF | | | | | | 4EMES | | | |
| CAT | cause. Enter UNDERLYING | | | | | | | | | | | |
| E | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | |
| AL C | PART il. Other significent conditions of | contributing to deeth b | ut not resulting i | n the underlyin | g cause given in | Part I. 24s. WAS A | N AUTOPSY | | VERE AUTOPSY FINDINGS | | | |
| 20 | AORTIC VAL | UE DIS | EASE | | | PERFO | RMED? | C | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| ME | | | | | | | ~ | 0.0 | THE TO NO | | | |
| ä | | | | | | | | / | | | | |
| PHYSICIAN: MEDIC | | IOSPITAL: | | 26. PI | LACE OF DEATH (C | heck only one) | | | | | | |
| 14S | 1 YES 2 NO 1 | ☐ Inpetient 2 ☐ ER/Outp 26e. DATE OF INJURY | | | | 8 Other (Specify) | | | | | | |
| ā | 1 Netural 5 Pending | (Month, Day, Year) | 28b. TIMI | URY WO | YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCU | RED | | | | |
|) BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY | - At home, ferm, a | | | 281. LOCATION (Street | end Number or | Rural Roi | rte Number | | | |
| COMPLETED | 4 Homicide determined | building, atc. (Spec | offy) | • | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| PLE | 29e. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the best of my know | ledge, death occurre | d at the time, date | end place, and due | to the cause(s) and m | enner es stated | | | | | |
| NO | O(19) 2 MEDICAL EXAMINER: (| | | | | | | | and menner as stated, | | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 3 | | | 29c. LICENSE NU | | | | Aonth, Day, Year) | | | |
| TO B | Wichoel a. Ille | | O. | | D-16 | 609 | ►JA | UCAB | 4 26, 1996 | | | |
| | MICHAEZ A. M | OSKEWICZ | MD. | Print) 503 B | YEN ST | CAMBR | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. DEGISTRAR'S SIGN | ATURE | , - , - | | | | | 216(2 | | | |
| | 31. DATE FILED (Month, Day, Year) JAN 2 9 1996 | Jalia d'avalu | or hardall | | | | | | 4. | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE OF MARYLAND REGISTRAR | / DEPARTMENT OF HEALTH AN | D MENTAL HYGIENE REG. NO. | | | | | | | | | |
|------------------|---|--|---|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | |
| | | MARSHALL | 01 23 96 10:10 P M | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. II | est birthday) IF UNDER 1 YEAR IF UNDER 24 HR MONTHS DAYS HOURS MIN | S. 7. DATE OF BIRTH A BIRTHRY ACE (State or Foreign | | | | | | | | | |
| | 212-09-4673 1 | YRS. | OCT. 28, 1914 MARYLAND | | | | | | | | | |
| Œ | WILLIAM HILL MANOR | 9b. CITY, TOWN OR LOCATION OF EASTON | F DEATH 9c. COUNTY OF DEATH TALBOT | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | EASTON | TALBUT | | | | | | | | | |
| E | 10a. STATE 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? | | | | | | | | | |
| | MARYLAND TALBOT 10e. STREET AND NUMBER | EASTON | 1 YES 2 NO | | | | | | | | | |
| FUNERAL | 23 CRAB APPLE COURT | 10f. ZIP CODE 2160 | 1 USA | | | | | | | | | |
| S | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A | RMED 13. WAS DECENDENT OF HIS | PANIC ORIGIN? (Specify Yes or No.— 14, RACE — American Indian. | | | | | | | | | |
| BY F | 1 Never Married 2 Married FORCES? 1 YES 2 X 3 Y Widowed 4 Divorced | | xican, Puerto Rican, atc.) Black, White, etc. Specify: WHITE | | | | | | | | | |
| 03 | 15. DECEDENT'S EDUCATION 16a C | ECEDENT'S USUAL OCCUPATION | 18b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| ET | (Specify only highest grade completed) | Give kind of work done during most of working (e. Do NOT use retired.) | IOS. KIND OF BUSINESS/MUUSTRY | | | | | | | | | |
| COMPLET | 7 | SEAMSTRESS | GARMENT FACTORY | | | | | | | | | |
| | 17. FATNER'S NAME (First, Middle, Last) | | NAME (First, Middle, Malden Surname) | | | | | | | | | |
| BE | EDWARD SEARS HARPER, SR. | 9b. MAILING ADDRESS (Street and Number or Ru | MARGARET FAIRBANK | | | | | | | | | |
| 유 | | P.O.BOX 1, ROYAL | | | | | | | | | | |
| | 20s. METNOD OF DISPOSITION 20b. PLACE | AND DATE OF DISPOSITION (Name of | OATE 20c. LOCATION City or Town, Stata | | | | | | | | | |
| | 4 Donalion 6 Other (Specify) SPRI | NG HILL CEMETERY | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | NEWNAM FU | NERAL HOME, P.A. | | | | | | | | | |
| Ų, | D. Belle Ponggen, | | RRISON ST., EASTON, MD | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused this d shock, or heert fellure. List only one cause on each lin | esth. Do not enter the mode of dying, s | Such as cardisc or reepiratory arrest, Approximate | | | | | | | | | |
| - 4 | IMMEDIATE CAUSE (Fine) | | | | | | | | | | | |
| | resulting in desth) a | ENAL DISH | 6 months | | | | | | | | | |
| z | Sequentially list conditions b. | | | | | | | | | | | |
| ATIC | if sny, isading to immediate cause. Enter UNDERLYING | OUENCE OF): | | | | | | | | | | |
| FIC | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSE | OUENCE OF): | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not | resulting in the underlying cause given | In Part I. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS | | | | | | | | | |
| ICAL | Hypen Tex 110~ | rooting in the underlying cause given | PERFORMED? AMAILABLE PRIOR TO | | | | | | | | | |
| B | | | 1 VES 2 PNO OF OCATH? | | | | | | | | | |
| ž | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA | ATH YES INO IN UNCERTA | | | | | | | | | | |
| PHYSICIAN: MEDIC | EXAMINER? HOSPITAL: | CE OF DEATN (Check only one) | | | | | | | | | | |
| 1YS | 1 ☐ YES 2 ☑ NO 1 ☐ Inpetient 2 ☐ ER/Outpetient 27. MANNER OF DEATN 28a. DATE OF INJURY | 3 DOA 4 Defuring Name 5 Realders 28b. TIME OF 28c. INJURY AT | ca 6 Cother (Specify) 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | |
| | 1 Netural 5 Pending (Month, Day, Year) | INJURY WORK? M 1 YES 2 NO | Zed. DESCRIBE NOW INJURY OCCURED | | | | | | | | | |
| D BY | 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At h | oma, farm, streat, factory, office | 261. LOCATION (Street and Number or Rural Route Number, | | | | | | | | | |
| | 4 Homicide determined | | City or Yown, State) | | | | | | | | | |
| COMPLETED | 29s. CERTIFIER (Check only one) Check only one) One) | | | | | | | | | | | |
| S | 2 MEDICAL EXAMINER: On the besis of axamination and/or | investigation, in my opinion, death occured at | the time, data and placa, and due to the cause(s) and menner as stated. | | | | | | | | | |
| BE | 296. BIGMATHIRE AND STIZE OF CERTIFIER | 29c. LICENSE I | NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | |
| 2 | 38. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH OTI | SI (Tron. Print) | 166 1124/96 | | | | | | | | | |
| | Ludwig J. Eg/scdenIII un. | 606 DUTChmans | (ast EN170~ md 21601 | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | LAIM | | | | | | | | | |
| - 1 | JAN 25 1996 Julia d'avaleon Ran | dalle | | | | | | | | | | |

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96 03791 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR Margaret Rebecca McKinstry 1996 9:00 AM January 31 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 1 - M 2 - F 87 166-32-4443 Jan. 4, 1909 Pennsylvania 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 811 Fisherman Lane Edgewood Harford RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY LIMITS? Maryland Harford Edgewood 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 811 Fisherman Lane 21040 USA 11. MARITAL STATUS 12, WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White ED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY COMPLET College (1-4 or 5+) Inventory Superintendant Education 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) David James McKinstry Clara May Allen BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy S. Johnson 811 Fisherman Lane, Edgewood, Maryland 20e. METHOD OF DISPOSITION
1 N Buriel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Harford Memorial Gardens 1/3/96 4 Donation 5 Other (Specify) Aldino, Maryland WILLY W 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 23. PART I/Enter the diseases, or complications that coused the decahock, or heart fallure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Md. complications that coused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) . Hyperkalaemia. Renal failure. 2 mmths DUE TO (OR AS A CONSEQUENCE OF): Mocardial Eschemia,
DUE TO (OR AS A CONSEQUENCE OF): 34m. CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Congestive Cardiomyopathy CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF that initiated events Myocardoal Enfarction reaulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 140 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN I PHYSICIAN: 26. PLACE OF DEATH (Check only 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL OTHER:
4 Nursing Home 5 Residence 8 - Other (Specify) 1 TES 2 NO 1 Inpatient 2 ER/Oulpatient 3 DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Netural Accident 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number City or Payre State) 3 Suicide COMPLETED 6 Could not be 4 Homicide

29e. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner se stated. 296. SECHATORE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D18424

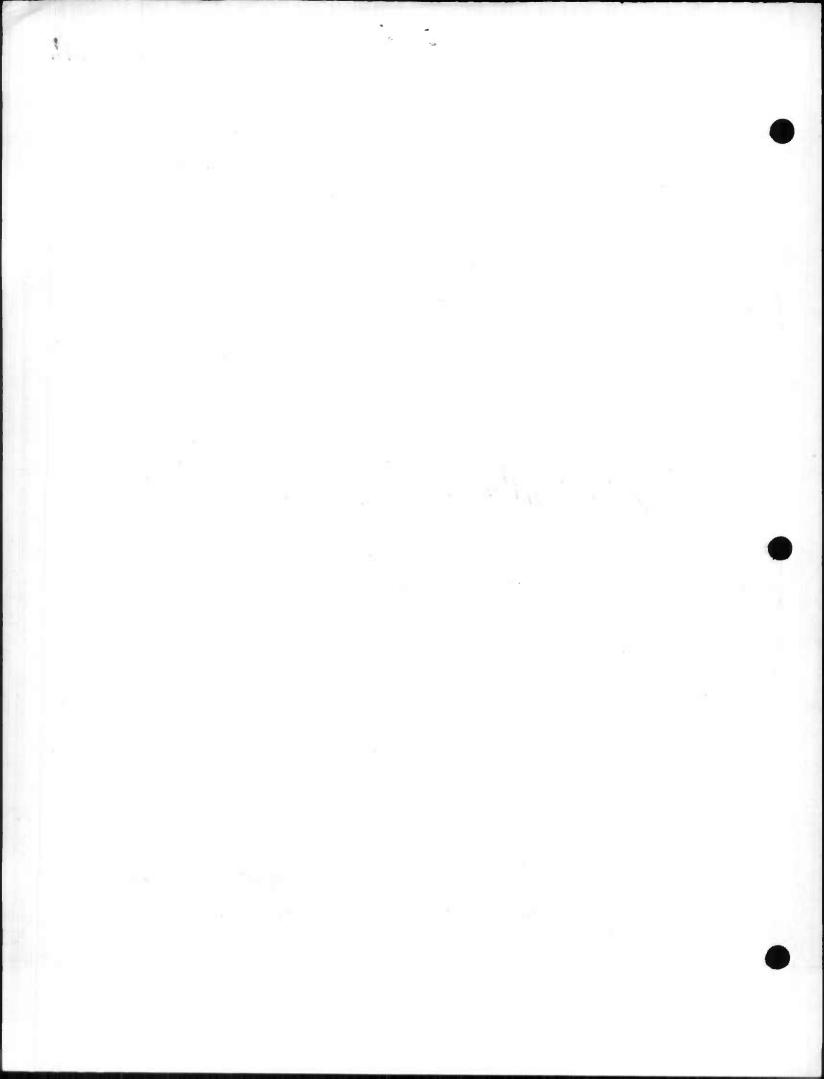
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

B.D. Parekh MD

408 HARFURD RUAD. BD.PAREKH MD. PALLSTON, MD 21047.

32. REGISTRAR'S SIGNATURE 1996

DAN-31-96

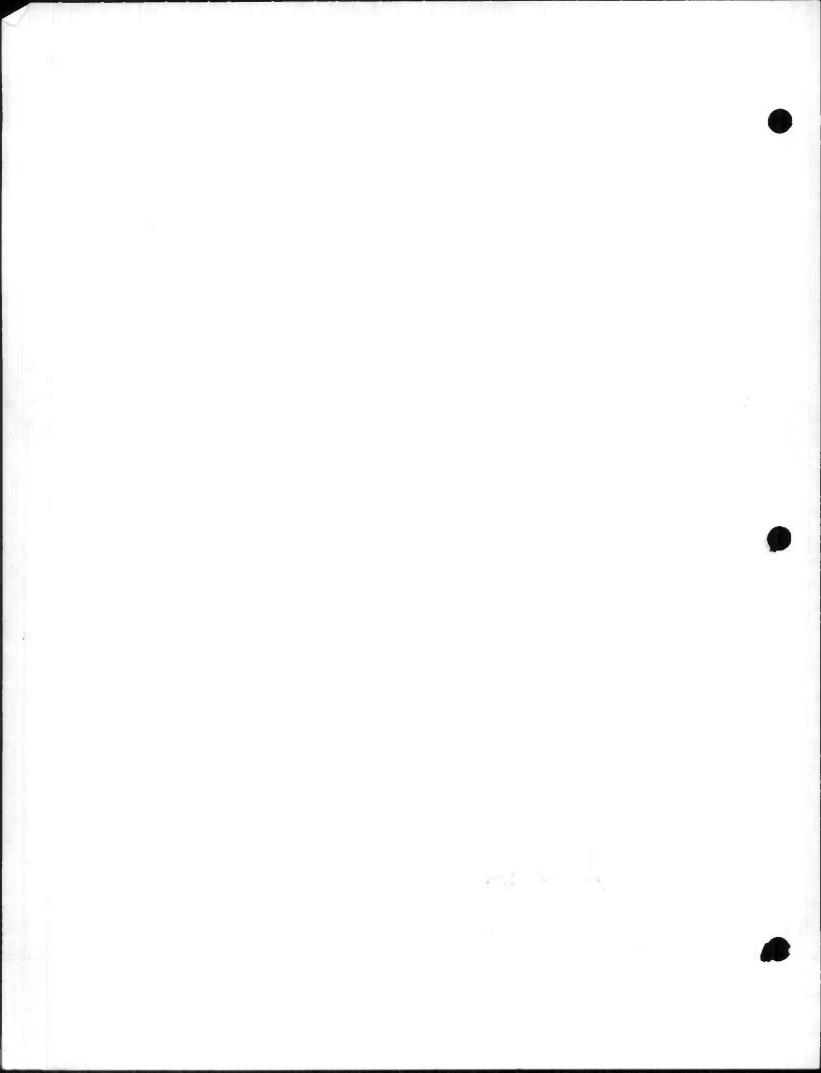


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERT | IFICATE | OF DEAT | H | REG. NO | | | | | |
|---------------|---|---------------------------------|-----------------------------|---|----------------------------------|------------|---------------------------------|---------------|---|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 3. TIME OF DEATH | | | | | | | | | | |
| | John William McCo | nne11 | | | | | | AY 100 | YEAR O. C. C. C. T. N. | | | |
| | 4. SOCIAL SECURITY NUMBER | | B. AGE (In yrs. last birtho | lay) IF UNDER 1 | YEAR IF UNDER | 24 MDS | January 26 | | 96 6:40 P N B. BIRTHPLACE (State or Foreign | _ | | |
| | 579 OF 2620 | 1 G.M 2 G F | | MONTHS | DAYS HOURS | MIN. | (Month, Day, Year) | | Country) | | | |
| | 578-05-3639 | Δ. | 81 YR | | | | October 1 | ,1914 | Washington, D.C. | | | |
| _ | Se. FACILITY NAME (If not institution, give a | treet end number) | | 9b. CITY, 1 | OWN OR LOCATIO | ON OF DE | ATH | 9c. COUN | TTY OF DEATH | | | |
| 6 | MedBridge Medical | | | Whe | aton | | | Mont | tgomery | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | HOH | Egomet y | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | 10c. | CITY, TOWN OR | LOCATION | | | | 10d. INSIDE CITY | | | |
| ā | Maryland Mon | tgomery | | Silver | Spring | | | | 1- YES 2 NO | | | |
| 4 | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | 10g. CITIZ | ZEN OF WHAT COUNTRY? | _ | | |
| FUNERAL | 9227 Longbranch P | arkman | | | 1 | 20 | 001 | | | | | |
| ΞI | 11. MARITAL STATUS | | EVER IN U.S. ARMED | T 49 W | O DECEMBENT OF | | 901 IIC ORIGIN? (Specify Yes | | U.S.A. | _ | | |
| | 1 Never Married 2 Merried | FORCES? 1X | YES 2 NO | H : | yes, specify Cuber | n, Mexica | n, Puerto Rican, etc.) | s or No- | 14. RACE — American Indian, Black, White, etc. | | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WA | | 1 (| YES 2 📆 NO | Specify | 7 | - 1 | Specify: | | | |
| | 15. DECEDENT'S EDUC | WW II | | | | | | | White | | | |
| 2 | (Specify only highest grade | | (Give kind | IT'S USUAL OCC f of work done du OT use retired.) | TUPATION ring most of working | g | 166, KIND OF BU | SINESS/INDI | USTRY | | | |
| ا ۳ | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | | | | | |
| ₹ I | 12 | | Servi | e Tech | nician | | Gener | al El | Lectric | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTH | IER'S NAI | ME (First, Middle, Melden | Sumeme) | | | | |
| BE | William Patterson | n McConne | 11 | | Et | the1 | Beatrice | Barro | ın | | | |
| | 19a, INFORMANT'S NAME (Type/Print) | | 19b. MAJI | ING ADDRESS (| Street and Number | or Rural F | Toute Number, City or Tow | m, State, Zip | Code) 20901 | | | |
| 2 | Alice B. McConnel | 1 | 1 | | | | | | 20901 ng Maryland | | | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DA | | | arkw. | DATE 20c. LO | Sprin | Olty or Town, State | _ | | |
| ł | 1 Suriel 2 Cremation 3 Rema | oval from State | cemetery, crematory | or other place) | | | | | | | | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | euge. | Glenwood | | | 1/ | 30/96 Wash | ingto | n. D.C. | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LIC | ENSEE | 1 1 | | ME AND ADDRES | | | 1 11 | _ | | | |
| | m_L | 1 | 1. // | | | | lins Funer | | | | | |
| | 23. PART I. Enter the diseases or o | complications that | caused the death. I | DUU | Univers | sity | Blvd.W. | Sils | Spr. MD 20901 | 4 | | |
| | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart fellure. List only one cause on each lins. Approximate interval Between | | | | | | | | | | | |
| ı | IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | | |
| | disease or condition resulting in death) | . Cardiop | ulmonary A | rrest | | | | | Minutes | | | |
| | | OUE TO (C | OR AS A CONSEQUENC | E OF): | | | | | Tituluces | | | |
| z | Cardiac Arrhythmias | | | | | | | | | | | |
| CERTIFICATION | Sequentielty list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 3 | cause. Enter UNDERLYING | Anoxia l | Brain Dama | ge | | | | | 10 Years | | | |
| Ē | CAUSE (Disease or injury that initiated events | DUE 10 (0 | OR AS A CONSEQUENC | E OF): | | | | | TO TESTS | - | | |
| 1 | resulting in death) LAST | Myocard | ial Infarc | tion | | | | | | | | |
| 8 | | | | | | | | | 10 Years | - | | |
| | PART II. Other aignificent condition | e contributing to d | eath but not resulti | ng in the und | erlying cause g | iven in I | Part I. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS | 1 | | |
| EDICAL | | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | | | | | | | 1 _ YES 2 | NO. | DF DEATH? | 1 | | |
| Σ | | | | | | | _ | | 1 TYES 2 NO | 1 | | |
| Z | | | | | | | | | | | | |
| ਰੋ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 26. PLACE OF DE | EATH (Che | ick only one) | | | | | |
| S | 1 TES 2 NO | | ER/Outpetient 3 🗆 DO | | g Home 5 🗆 Res | eldence | 6 Other (Specify) | | | 1 | | |
| PHYSICIAN: | 27. MANNER OF OEATH | 28e. OATE OF IN (Month, Day) | | TIME OF 2 | Bc. INJURY AT WORK? | | 28d. DESCRIBE HOW I | NJURY OCC | URED | ٦ | | |
| ВУ | 1 K Natural 5 Pending investigation | (Mondi, Day, | 7007 | M | 1 YES 2 | NO | | | | 1 | | |
| | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF | INJURY — At home, far | m, street, factor | y, office | | 281, LOCATION (Street | and Number of | or Bural Boute Number | Н | | |
| COMPLETED | 4 Homicide determined | building, et | c. (Specify) | | | | City or Town, State) | | or recommended recomments, | 1 | | |
| <u>u</u> | 29e. CERTIFIER | | | | | | | | | 4 | | |
| Ē. | (Check only 1 K CERTIFYING PHYSIC | | | | | | | | | 1 | | |
| ō I | 2 MEDICAL EXAMINE | t: On the belts of exa | mination end/or investig | ation, in my opi | nion, death occurs | d at the | time, date and place, en | d due to the | cause(e) end manner es stated. | 1 | | |
| | 296. SIGNATURE AND TITLE OF SERTIFIER | 1 1 | 1 | _ | 29c. LICEI | NSE NUM | BER | 29d DATE | SIGNED (Month, Day, Year) | Н | | |
| BE | 12 chu e | otto | Jusa | | D 44 | 120 | | | | 1 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALLER | OF DEATH OTEM AT | Former Desirate | D 44 | 120 | | Jan | uary 27,1996 | 4 | | |
| | | | | | | | | | | | | |
| | Takao L. Sato, M. | | Rockvill | e Pike | Rockvi | 11e, | MD 2085 | 2 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTBAR | S. SIGNATURE | | | | | | | 1 | | |
| - 1 | JAN 30 1996 | faire alau | many mandall | | | | | | | | | |
| | | | | | | | | | | | | |



| | retaine | 5 shou |
|---|---|--|
| ĵ | lay be | page |
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2s hours after death. Page 6 may be retained | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shou be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| | ith. Pa | neral d |
| | ter dea | the fu |
| | ours af | in by |
| | 24 In | filled tion, o |
| | within | pletely |
| | ecuted | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| | be es | cian a |
| | Uficate | physi- |
| | th cert | ending I Hygis |
|) | ne dea | the att |
| | that th | od by |
| | quires | n sign f Heaft |
| | law re | as bee |
| | I: The | State D |
| | SICIA | certifi h the |
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| | ENDIN | R: Aft ter dea |
| | TIN H | INECTO |
| | TAL C | RAL D |
| | HOSP | FUNE |
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| | - Server | - 0 |

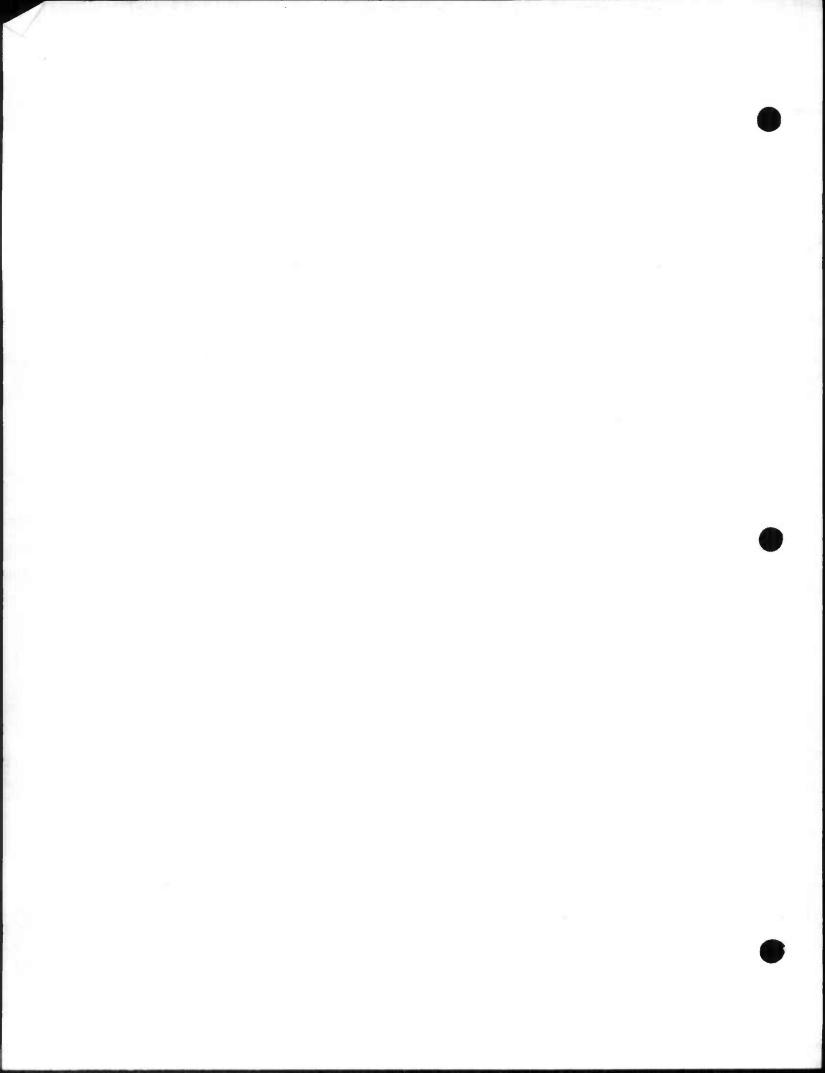
AMOL RAKKAR, M
31. DATE FILEO (MONTH, Day, Year)
JAN 3 0 1996

M.D.

32. PEGISTRAP'S SIGNATURE

| | FOR 1 STATE | STATE OF MARY | | | | | | | MENTAL HYGIE | | 0 | 0379 | J |
|---------------|---|---|---|------------------------------|----------------------|------------|------------------------------------|---|--|-----------------------------------|--------------------|---------------------------------------|-------|
| | REGISTRAR | | CI | ERTIFI | CATE | OF | DEAT | Ή | REG. N | 0. | | | |
| | 1. DECEOENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH | DATE OF DEATH DAY YEAR 3. TIME OF | | | | | | | | | | |
| | CHARLOTTE CELEAN | | | | | | | | JANUARY | 24, 1 | 996 | 6:00 | Pw |
| | | 1000 | E (In yrs. les | | IF UNDER 1 | DAYS | HOURS | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH Countr | PLACE (State or For | reign |
| 1 | 1220 34 4020 | □ M 2 💢 F | 55 | YRS. | MONTHS. | OM78 | HOUNS | milita. | 12/22/194 | 0 | | ginia | |
| | 9a. FACILITY NAME (If not institution, give street | FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEJ | | | | | | | | 9c, CO | UNTY OF D | | |
| CTOR | National Institute | of Health | | | Bet | hesd | a | | | Mor | ntgom | ery | |
| DIREC | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | Virginia Fairfax Springfield | | | | | | | | | | | 1 YES 2 X | NO |
| FUNERAL | 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT (| | | | | | | | | | | | |
| y | 5507 Kathleen Place | | | | | | 2151 | _ | | USA | | | |
| B | 11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced | R IN U.S. AR ES 2 XII R DATES | MED NO | - 11 | MS DECE yes, spec | Ify Cuban | F HISPANI , Mexican Specify: | C ORIGIN? (Specify) , Puerto Ricen, etc.) | es or No- | 14. RACE Block Speci Whi | | in, | |
| 8 | 15. DECEDENT'S EDUCATI | | 16a. DE | CEDENT'S U | SUAL OC | CUPATION | | | 16b. KIND OF B | USINESS/IN | | | |
| | (Specify only highest grade com Elementary/Secondary (0-12) | ollege (1-4 or 5+) | (G | ive kind of wo Do NOT use | retired.) | uring most | of working | 7 | | | | | |
| 1 | 10 | onege (1-4 or 5 +) | C1 | erk | | | | | Retai | 1 5-1 | AC | | |
| COMPL | 10 Clerk 17. FATHER'S NAME (First, Mickille, Last) 16. MOTHER'S NAME (First, | | | | | | | | | | | | |
| BEC | | Randolph Milton Moore Julia Eliza | | | | | | | | | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAJLINO / | DDRESS | (Street an | d Number | or Rural R | oute Number, City or To | wn, State, Z | ip Code) | | |
| TO BE | James Woodward 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7332 Beulah Street, Alexandria, Virginia | | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION City or Town, State | | | | | | | | | | | | |
| | 1 Mx Burfal 2 Cremation 3 Removal from State Cemetery, crematory or other place) | | | | | | | | | | | a | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | |
| | Richard Garage Demaine Funeral Homes, Inc. Alexandria, Virginia 22314 | | | | | | | | | | | | |
| ERTIFICATION | ahock, or heart feliure. List only one ceuse on each line. | | | | | | | | | | | Approxima Interval Be Onset and | tweer |
| | a | DUE TO (OR A | S A CONSE | UENCE OF | | - 4 | C - | | | | | \$1000 | 11 |
| S | Sequentially list conditions. | | | | ra | 2 | 0 | w | ies | | | a/ me | חשור |
| Ĕ | Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | | | | | | | | | | | | |
| 부 | that initiated eventa resulting in death) LAST | DUE TO (OR A | S A CONSE | DUENCE OF) | | | | | | | | | |
| | d | | | | | | | | | | | | |
| | PART II. Other algorificant conditions co | ontributing to death | hut not r | anultina in | the send | tochilos | | huan da F | and I am uma a | | T and | | |
| EDICAL | | | | ooditing in | tire dire | only my | cause g | 14611 111 7 | | N AUTOPSY PRMED? | 240. | WERE AUTOPSY FIN AVAILABLE PRIOR T | то |
| DIC | | | | | | | | | 1 YES | 2 NO | | OF DEATH? | AUSE |
| : MEC | | | | | | | | | | , , | | 1 YES 2 PN | ю |
| AN | DID TOBACCO USE CONTRIB | UTE TO CAUSE | OF DEA | TH YES | | 10 🗆 | UNC | RTAIN | 之 | | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLAC | E OF DEATH | (Check or | nly one) | | | | | | | |
| | | OSPITAL: Synpetient 2 - ER/O | ulpatient 3 | | OTHER: | | 5 Ree | idence f | Other (Specify) | | | | |
| PHY | 27. MANNER OF DEATH | 28s. DATE OF INJUR (Month, Day, Year | | 28b. TIME INJU | OF : | 28c. INJU | RY AT | | 28d. DESCRIBE HOW | INJURY O | CURED | | |
| ВУ Р | 1 Natural 5 Pending Investigation | | | - | M | | S 2 🗌 | NO | | | | | |
| TED E | 3 Suicide 8 Could not be 4 Homicide detarmined | 26a. PLACE OF INJU building, atc. (S | RY — At ho pecify) | me, farm, str | ree1, factor | ry, office | | | 281. LOCATION (Stree City or Town, Stat | and Number | or Rural R | loute Number, | |
| | | | | | | | | | | | | | |
| MPLE | 29a. CERTIFIER (Check only one) | | | | | | | | | | | | |
| | 2 MEDICAL EXAMINER: O | n the basis of exemina | tion and/or i | investigation. | Іп ту ор | inlon, de | th occure | d at the t | lme, data and place, | end due to t | the cause(s | and manner as sto | ated. |
| ō | / | | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c | | | | | | | | | | |
| O BE COM | | MA | | | | T | 29c. LICE | NSE NUMI | BER | 29d. DA | TE SONED | (Month, Day, Year) | |

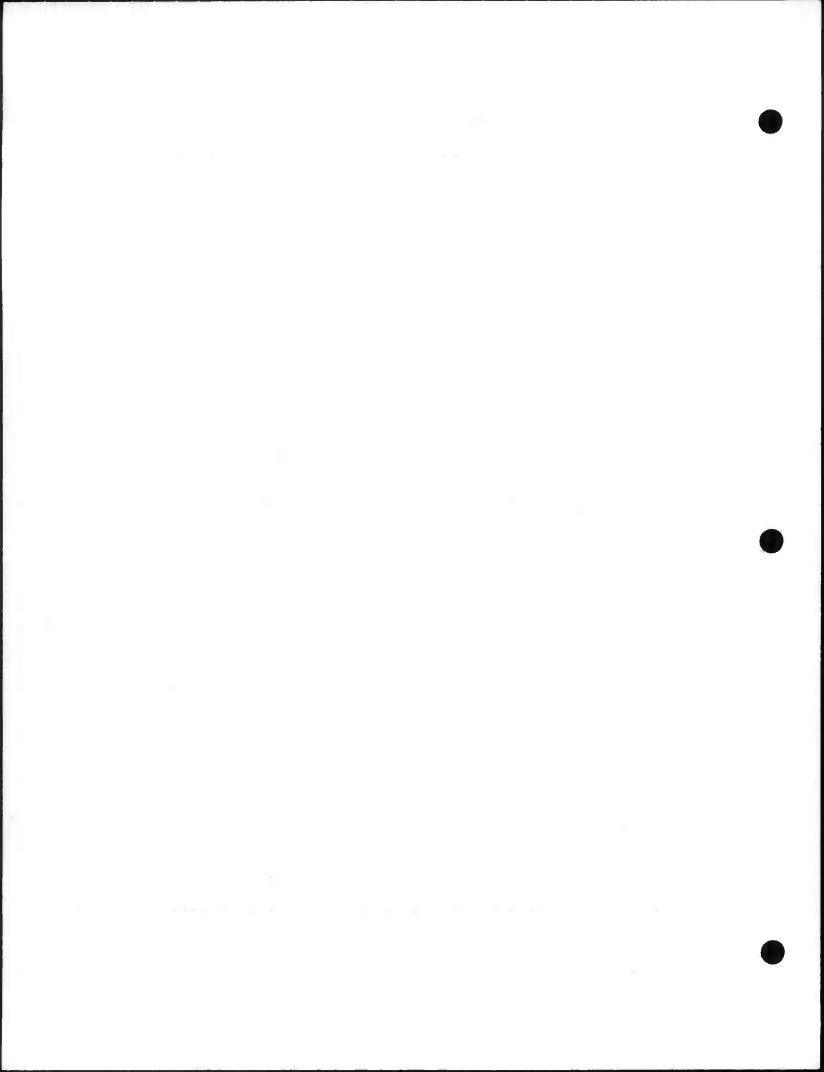
9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892



| 68760 |
|----------|
| BOX |
| P.O. |
| RDS, |
| RECORDS |
| /ITAL F |
| OF VI |
| NOI |
| DIVISION |
| |

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|

| | 1 - FOR STATE OF MARYLAND / OEPARTMENT OF HEALTH CERTIFICATE OF DEAT | AND ME | NTAL HYGIENI REG. NO. | E | | | | | | | | | |
|------------------|--|---|---|-------------------|---|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 3. TIME OF DEATN | | | | | | | | | | |
| | AGNES EBBIE NELSON | | DATE OF DEATH DA | 1996 | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER | | RTHPLACE (State or Foreign | | | | | | | | | | |
| | 578-20-1947 1 M 2 X F 71 YRS. MONTHS DAYS HOURS | MIN. | O 8 / 2 4 / | 24 Wa | shington D.C. | | | | | | | | |
| | Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION | ON OF DEATN | | 9c. COUNTY C | | | | | | | | | |
| FUNERAL DIRECTOR | Fort Washington Hospital Fort Washington Prince Geo | | | | | | | | | | | | |
| H | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10 | | | | | | | | | | | | |
| ā | Maryland Charles Bryans Road | | | | 1 YES 2 NO | | | | | | | | |
| M | 104. STREET AND NUMBER 101. ZIP CODE | E | | 10g. CITIZEN (| OF WHAT COUNTRY? | | | | | | | | |
| ij | 2156 Crest Circle 206 | 16 | | U.S. | A. | | | | | | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECEMBENT O 14. WAS DECEMBENT O 15. WAS DECEMBENT O 16. WAS DECEMBENT O 17. WAS DECEMBENT O 18. WAS DECEMBENT O 19. WAS DECEMBE | | | | IACE - American Indian, Black, White, etc. | | | | | | | | |
| BY | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2X NO | | 10011, 010.) | | pecify: | | | | | | | | |
| | 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION | | | | White | | | | | | | | |
| ET | (Specify only highest grade completed) (Give kind of work done during most of workin life. On NOT use primed) | ng | 18b. KINO OF BUS | INESS/INDUSTR | Υ | | | | | | | | |
| 7 | Elementary/Secondary (0-12) College (1-4 or 5+) 12 Operator | | Wells | Farqo | | | | | | | | | |
| COMPLETED | Operator | HER'S NAME (| First, Middle, Melden 3 | | | | | | | | | | |
| BE C | | th O. | | | | | | | | | | | |
| | 110 | | | , State, Zip Code |) | | | | | | | | |
| 2 | Sharon Childress Same as #10 | The American College and Parisher or Aural Auditor College and Touris Auditor College (College) | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Disposition 3 Removal from State 20b. PLACE AND DATE OF CISPOSITION (Name of Campillary Committee) or other place) | | DATE 20c. LOC | CATION - City o | r Town, State | | | | | | | | |
| - 1 | 4 Donation 5 Other (Specify) Lee Funeral Home Janu | uary28 | ,1995 CL | inton, | Maryland | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRES | SS OF FACILIT | Υ | | | | | | | | | | |
| | Modes Modes Williams Rt. 225 | | | | W 7 W 3 206 | | | | | | | | |
| | 23. PART t. Enter the diseases, or complications that caused the death. Do not anter the mode of dvi | ing, such sa | cardisc or respir | Inclair | Head, Md. 206 | | | | | | | | |
| | shock, or has/t fellure. List only one cause on each line. IMMEDIATE CAUSE (Flori) | shock, or has t failure. List only one cause on each line. | | | | | | | | | | | |
| - 1 | disease or condition ACUTE DESCROTONI F | 21/1 | DE | | Onset and Death | | | | | | | | |
| | resulting in death) a. A CUTE RESPIRATORY F OUE TO (OR AS A CONSEQUENCE OF): | CLILA | VICE | | | | | | | | | | |
| z | - Chronic Obstructive mul | mon | ary do | GPA CT | = 17dAYS | | | | | | | | |
| 임 | Sequentially list conditions, If sny, leading to immediate oue to (or as a consequence of): DUE TO (or as a consequence of): DUE TO (or as a consequence of): | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury C. CAVOMC TO BACCO ABUSER | | | | | | | | | | | | |
| E | that initiated events PUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | | | |
| 5 | d | | | | | | | | | | | | |
| AL C | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24s. WAS AN AUTOPSY FINDINGS | | | | | | | | | | | | |
| 2 | | | PERFORI | | AMILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | |
| | | | I L TES E | N NO | OF DEATH? | | | | | | | | |
| - | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🕱 NO 🗆 UNC | ERTAIN [| - l | | I ES 2 E NO | | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) | | | | | | | | | | | | |
| Sic | HOSPITAL: 1 YES 2 NO HOSPITAL: 1 On Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Name 5 Ref | sidence \$ □ | Other (Specify) | | | | | | | | | | |
| 美 | 27. MANNER OF CEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT | | . DESCRIBE NOW IN | JURY OCCURED | , | | | | | | | | |
| ВУ | 1 Netural 5 Pending 2 Accident Investigation (Montal, Day, real) M 1 YES 2 | NO | | | | | | | | | | | |
| | 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office | 281. | LOCATION (Street ar City or Town, State) | nd Number or Rui | rel Route Number, | | | | | | | | |
| | 4 Homicide detarmined | | ony or lown, orang | | | | | | | | | | |
| 3 | 29e. CERTIFIER (Check only 1) CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, | , and due to th | e cause(s) end menr | ner as stated. | | | | | | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurs | ed at the time, | date and place, and | due to the caus | e(a) and menner as stated. | | | | | | | | |
| | 296. SIGNATURE AND TITLE OF CERTIFIER /) 29c. LICE | NSE NUMBER | Т | 29d. DATE,SIGN | IED (Month, Day, Year) | | | | | | | | |
|) BE | | 3512 | | ► 1/as | 3/96 | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) | | 1 | 1010 | 110 | | | | | | | | |
| | DEIDRE VARNER 10274 Lake Arbor Way #205 | Mitch | hellvil | le,MD | 20712 | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | - | | | | | | | | | | |
| | JAN 3 1 1996 Julia Dhucker Randall | | | | | | | | | | | | |



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyglene 9 6 0 3 7 9 5

| _ | | | | | | Certi | ficate of | Death | | R | eg. No. | | 013 | | | |
|----------------------------|---|----------------|--|--|--|----------------------------|----------------------------------|--------------------------------|----------------|------------------------------|-----------------------------------|--------------------------|---|-----------|--|--|
| 8 | Physic | an | Decedent's Name (First, Middle | | | | | | | Dete of Dea Month | th Day | Year | 3. Tima of | Death | | |
| B | /Medi | | JAMES | | ICK | | | | | | 29 | 96 | (23 | 35 | | |
|) | Exami | | 4e. Fecility Name (if not institution, | give street and number) | | | | 4b. City, Tow | m, or Locati | on of Death | 4o. County | of Death | | | | |
| | | | UNIVERSITY | of M | KYLAND |) | | BALT | TIMOR | E | BALT | MOR | 5- (| LITY | | |
| П | Funeral | | | 8. Sex 7. As | ge (In yrs. last bli | | If Under 1 Year | If Under 2 | 4 Hre. 8. | Date of Birth (Month, Day | Vasul | | lece (State of | r Foreign | | |
| | Director | | 191-34-0628 | 1 M 2□ F | 52 | Yrs. | Monthe Deye | Hours | Min. | May 5 | 1943 | | sylvan | | | |
| | ъ | | Usual Residence of Decedent | | | | | | | | | | -, - , | | | |
| | ylan | | 10a. State 10b. County | | 10c. City, Tow | m or Locat | tion | | | | | 1 | 0d. Ineida Cit | y Limite | | |
| | W TE | to | Md Ca | rroll | We | stmir | nster | | | | | | 1 Yes | 2 No | | |
| | 72 hours after death with the Maryland "netural", or items 23s or 28s-f show diget Example, must be notified at | Director | 10e. Street and Number | 10f. Zip Code | in La | | 1 | 0g. Citizan of | | Vhat Country? | | | | | | |
| | th w | | | | | | | | | | United | Stat | es | | | |
| | dea F | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | Ever In U,S. | 13. Wa | s Decedent of I | Hiapanic Origi | in? (Specify | Yes or No- | | e - Amario ok, Whita, | | | | |
| 0 | or its | | 1 Never Married 2 Marrie | | Novietnan | | Yes 2 No | | 1 00110 1 1100 | iti, ato., | | | aro. | | | |
| 02 | Surgar Part | by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | VIETICIA | 1 | 3 198 Z JAQ 190 | Specify: | | | Specify | ν: | White | , | | |
| 50 | 72 hc | ted | 15. Decedent' (Specify only highest | Education | 18a. | . Deceden | nt'e Usuei Occup | petion | of working | | 15b. Kind of B | uelnees/inc | lustry | | | |
| 21 | C . E . | ple | Elementary/Secondary (0-12) | College (1-4or | 5+) | | d of work done NOT use retire | | or working | | Mahia | 1 0 | | | | |
| Maryland 21215-0020 | 77 Ton Law World | Completed | senior analyst | | | | | | Natio | | | onal Security | | | | |
| pu | be filed that Hygid d other event, II | Be (| 17. Father's Name (First, Middle, L | ast) | | | | 18. Mother | 's Neme (FI | rat, Middle, i | Melden Surnen | n <i>e)</i> | | | | |
| /lai | should by | To | Edward F. Novi | ck | | | | E | leano | r M. K | atkavio | ch | | | | |
| an | | | 19a. Informant's Name/Relationsh | p (Type, Print) | 19b | o. Mailing | Addrase (Street | t end Number | or Rural Ro | oute Number | , City or Town, | Steta, Zip | Code) | | | |
| | 5 # 12 # T | | Christine Novi | ck | | | 401 Wa | rfield | Jehuro | Dd. | Westmin | ator | WD 21 | 157 | | |
| re, | ges 1 a f of Hee if item or othe | | 20a. Method of Disposition | | 20b. Place o | d Dispositi | ion (Neme of tony or other pla | | | ata | 20c, Location - | City or To | wn, Sieta | 13/ | | |
| 20 | Pages net of H int: If ite | | 1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp | | Cernete | ry, cremar | tory or other pla | 0: | 2/01/9 | 01/96 | | | | | | |
| Baltimore, | Department Department Important: any injury once. | | 21. Signature of Funeral Service L | | Ev | | en Memo | | | ns | | Fink | sburg, | MD | | |
| Ba | permit. F Departme Importan any injur | | 21. Ogradu o o ranotal contro E | - | | F | Pritts 1 | Funeral | 1 Home | | | | | | | |
| _ | | | Katherine 4 | Pietts - Sur | ter | | 112 Wasl | | | | | r, MD | | | | |
| В | | P | 23a. Part1. Enter the disease, or of shock, or heart failura. List of | omplications that cause nly one cause on each i | d the death. Do | not enter t | the mode of dyl | ng, such as c | ardiec or ra | epiratory err | eet, | i | Approximate Interval Baty Onest and D | veen | | |
| | Physician | | | | | | | | | | | 1 | Oneat and D | aatn | | |
| 信 | /Medical Examiner | | Immediate Cause (Final disease or condition | CER | RSLOVI | ASCIL | LAR | ACCID | ENT | | | i | 48 h | rs. | | |
| в | LAGITITICI | | resulting in death) | | Dua to (or es a | | | N | | | | 1 | | | | |
| | D = | Examiner | | - Prob | ASUE, | AOUT | IC DI | SSIECT | TON | | | | 724 | rs. | | |
| | icate be axecuted physician and s the burial-transit | am | Sequentially list conditions, | 0. | Due to (or as a | | | | | | | | | | | |
| Ó | e axe ian a urial- | Û | Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury | ATHER | 05010 | 4 O T | -1c 1 | ASTIL | AR | DISTER | 15-8 | THE CANADA | YEM | 2 | | |
| 68760, | nte b nysic | Aedicai | cause. Enter Underlying Cause (Disease or Injury Intal initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | | |
| | certificate be axecuted rding physician and use as the burial-transit | | Toobiang in boating Last | | | | | | | | | 1 | | | | |
| Box | endi. | Physician/R | d | | | | | | | | | | | | | |
| m. | that the death ce ed by the attendi detached for use | sici | Part ii. Other significant condition | contributing to death b | ut not resulting in | n the unde | erlying cause git | ven in Pert I. | | 23b. Did to | becco use co | ntributa to | the cause o | f deeth? | | |
| P.O. | E 50 | hy | | | | | | | | 1 Yee 2 No 3 Probably 4 | | | | Jnknown | | |
| | | ру Р | COLONAY | ALTERY | DISRASI | 2 | | | | | | | | | | |
| Ď | law requires as been sign 2 should be | B | | | | | | | | 24e. Wes e | | 24b. We | re autopay fi | ndings | | |
| 8 | bee sho | iet | ROLIC . | STENOSIS | | | | | | perfor | madr | 001 | plieble prior to impletion of or deeth? | uee | | |
| Re | The law ate has page 2 | Completed | 112.04 | | | | | | | 4.76 | 00 2 No | 1000 | | | | |
| ē | icate icate | | HYPRITEN | SION | | | | | | | | 11 | Yee all | NO | | |
| Ī | Physician: The la this certificate ha ral director, page | Be | 25. Was case reterred to medical examiner? | Hospital: | | | Ott | han | | heck only or | | | | _ | | |
| o | this ral di | To | 1 Yes 2 No | 1 Inpatie | | | 3 DOA | 4 P MAIS | 7 | | ence 8 DOth | | 1) | | | |
| Division of Vital Records, | Attending Phi or death. octor: After thi by the funeral | Certification: | 1 Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | y Year) 280. | Tima of Injury | 28c. Inju Wo | | | Describe III | ow injury occur | rea | | | | |
| Sic | Attending or death. ector: After by the fune | cat | 2 Accident investige 3 Suicide 8 Could no | nt he | | | | Yes 2□N | | | | | | | | |
| ≥ | | E | 4 Homicide determin | ad 200. Place of Ini | ury - At home, fa c. <i>(Specify)</i> | arm, atreet | , factory, offica | | 281. | City or Town | treet end Numb n, Stete) | per or Rure | Poura Numi |)ar, | | |
| | raf D | | | | | | | | | | | | | | | |
| | Hosp 4 ho Fune felly fi | edicai | (Check only 2 Madical E | Physician: To the best caminer: On the basis of | l examination an | a, death od id/or inves | ccurred at tha ti | me, dete end opinion, deeth | pieca, end | due to the c | euse(s) and mo lete and place, | end due to | eted. tha osusa(s) | | | |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in | Med | one) | and manner st | ated. | | | | | | | | | | | |
| | To To | - | 29b. Signature and title of certifier | 10 n1 1 | Took | | 29c. Liceni | | | 2 | 9d. Data eigna | d (Month, | uay, Year) | | | |
| 2 | | | Timothy | 13. Dil | | M.D. | D, | 4298 | l | | 1/ | 29/9 | 6 | | | |
| - | | | 30. Name and address of person w | | | | | | | | 1 | 1 | - | | | |
| | | | TIMOTHY & | GILBERT | I. M.I |), 6 | 22 5. | GREEN | J_ST | BA | LTIMO | UE 1 | 10 2 | 1201 | | |
| | Sta | te | 31. Date tiled (Month, Day, Year) | 1 1996 32. Registr | ar's Signature | 0. | -44 | | | | | , | | | | |
| | Registr | ar | JAN 3 | 1 1996 July | anulier | rada | LG | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 03796 Certificate of Death 1. Decedent's Neme (First Middle Lest) 2. Dete of Death 3. Time of Death **Physician** FEBRUARY I MARTE NICHOLS 1996 11:15 /Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SHADY GROVE NURSING HOME ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Houra Min. (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Deys Yrs Director SEPT, 22, 1905 220-32-6238 90 MARYLAND Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Peges 1 and 2 should be filed within 72 hours efter death with the Marylan enert of Health and Mental Hygiane.
Inti. If them 27 is marked at the "natural", or items 23a or 28a-f show inti. If them 27 is marked other than "natural", or other traumatic event, the Mapical Expr. ne. mail to motify at a ray or other traumatic event, the Mapical Expr. ne. 1 Yes 2 No MARYLAND MONTGOMERY Director DAMASCUS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 24506 FOSSEN ROAD UNITED STATES Completed by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Yes 2 No f Yes, Give Yeer or Dates: 21215-0020 1 ☐ Yes 2 No Specify: WHITE 3 ₺Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be JAMES SPRING CATHERINE **EDWARDS** 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LEO T. NICHOLS, JR. 3780 MAPLECREST CT., KNOXVILLE, MARYLAND 21758 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Pege Department of Important: If any Injury or once. HYATTSTOWN CEMETERY 2/8/96 HYATTSTOWN, MARYLAND 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility MURIEL H. BARBER FUNERAL HOME mure P.O. BOX 5038 LAYTONSVILLE, MARYLAND 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel 0700 disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner hypertension The law requires that the death certificets be executed Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last and Due to for es e consequence of): Box 68760. Due to (or es e consequence of): Physician/Medicai Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown lung discase, etnal Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed disease combrovescular dementiz 2 1 No 1 Yes 2 No of Vital 25. Wes case referred termedical exeminer? Be 26. Pisce of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 □Other (Specify) 1 Yes 2 No Certification: To 曹 27. Menny of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division Alber 5 Pending Investigation Attending Neturel if or Attending after death. Director: All 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide Hospital 24 hours a 29a. Certifier 1 👺 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29b. Signature and title of pertition 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 5, 1996 cause of deeth (Item 23e) (Type, Print) 30. Neme and eddress of person tever olinsky mo 19530 Ductors Drive. Germentourn Md. 2007

32. Registrar's signeture Raylell

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

• soft to the second seco

Pages 1, 2, 3 should funeral director, page 5 should be detached for use as the burial-transit permit. 24 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by completely executed within

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

in by the furnitude ő cremation, and com o burial, o prior to the attending physician Mental Hygiene prior to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

\$1194

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH CHARLES THOMAS NETZER SR. 1996 January 30. 1:05 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) S. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 | F 235-66-8990 May 16, 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memorial Hospital Cumberland Allegany RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Allegany Cumberland TY YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 108 E. Elder Street

11. MARITAL STATUS

12. WAS 1 21502 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, stc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 TYES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Cozy Corner 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) notified at Mary (Eaton) George E Netzer 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20s. METHOD OF DISPOSITION

10f Burlet 2 Cremetion 3 Removal from State
41 Donation 5 Dishar/Sharifid Elder Street: Cumberland, MD 21502 eq 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Donation 5 Other (Specify) 02/01 Memorial Cemetery 02 Cumberland, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scarpelli Funeral Home Cumberland, MD 21502 medical 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each ilns. Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition ACUTE LEFT VENTRICULAR FASILIRE resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF); CERTIFICATION Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events CIRRHOSIS Q= LIVER DECOMPENSATED
DUE TO (OR AS A CONSEQUENCE OF): other t resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS DIRECTOR: After this certificate has been signed by ti hours after death with the State Dept. of Health and I item 28 is marked, or item 23 shows any in AVAILABLE PRIOR TO HYDNATREMIA COMPLETION OF CAUSE 1 YES 2 1 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 | YES 2 | NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(e) and manner as stated. (Check only one) TO THE HOSPITAL TO THE FUNERAL C be filed within 72 h 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE M.D 3181- JAN. D 19318 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. N. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502 31. DATE FILED (Month, Day, Year) FEB 01 1996

CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

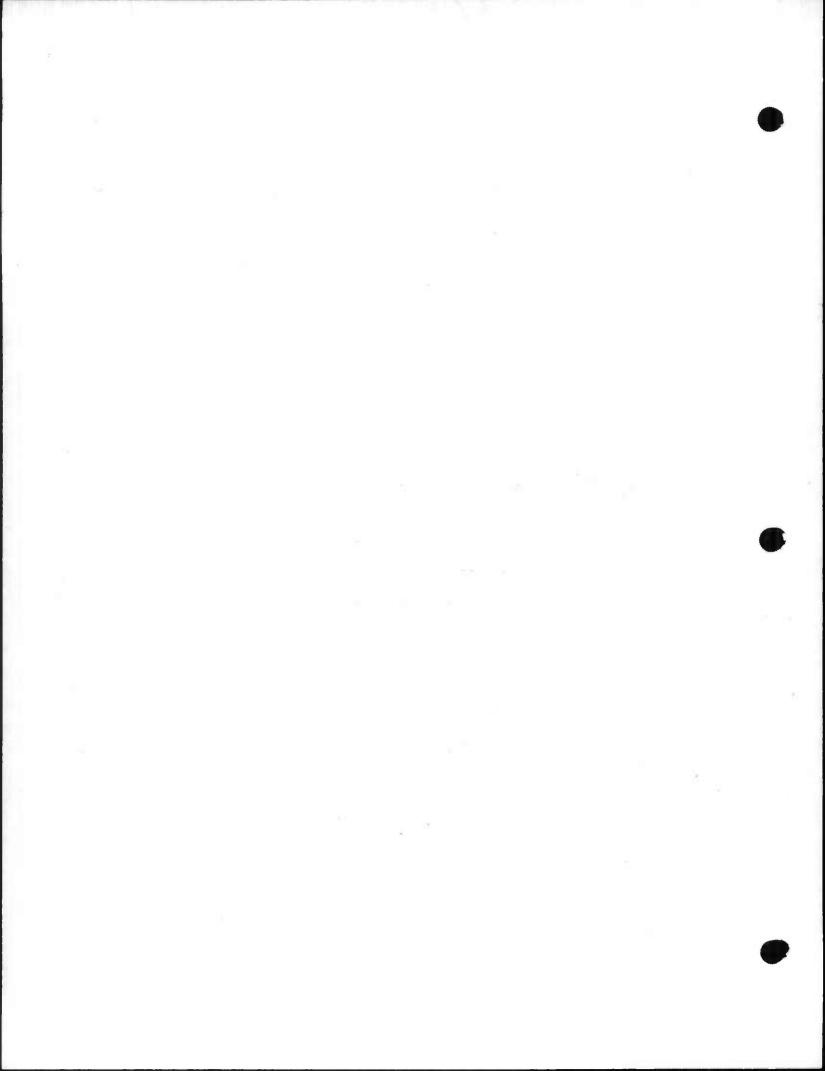
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| _ | REGISTRAN | | | -NIIII | CALE | JF DEF | VI III | R | EG. NO. | | | |
|---|--|--|-------------------------------|----------------------------|----------------------------|--------------------------------------|---------------|-------------------|--------------|--------------------------------|------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | LENA | MAY | NICH | OLS | | | 2. DATE OF S | DA | | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. | AGE (In yrs. les | -> | | | | JAN | | -6 | 1998 | |
| | 217-42-3274 | | WONTHS DA | - | MIN. | 7. DATE OF B (Month, De AUG. 9 | y, Year) | 07 | Count | HPLACE (State or Foreign OHIO) | | |
| | 9e. FACILITY NAME (If not institution, give si | treet end number) | | | 9b, CITY, TO | WN OR LOCA | | | , | | JNTY OF D | |
| œ | WILLIAMSPORT NUR | DOTNIC HOME | | | | | | | | | | |
| 6 | RESIDENCE OF DECEDENT | WING HOME | | | | MITI | IAMSI | ORT | | | WASH. | INGTON |
| | 10e. STATE 10b. COUNTY | 1 | | 10c, CITY. | DC. CITY, TOWN OR LOCATION | | | | | | | 10d. INSIDE CITY |
| MARYLAND WASHINGTON HAGERSTOWN | | | | | | | | | | | | LIMITS? |
| | | | | | | | | | | | | 1 ☐ YES 2 X NO |
| Of all Code | | | | | | | | | | 10g. CIT | IZEN OF V | WHAT COUNTRY? |
| 핒 | 10420 BAILEY ROA | | | | | | 217 | 742 | | | U.5 | 5.A. |
| ᆵᅵ | 11. MARITAL STATUS | 12. WAS DECEDENT EV FORCES? 1 | YER IN U.S. AR | MED | 13. WAS | DECENDENT | OF HISPAN | IC ORIGIN? (S | pecify Yee | or No- | 14. RACE | E — American Indian, k, White, etc. |
| BY | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR | | | 1 [| YES 2 OKNO | Specify: | , Puerto Rican | 1, etc.) | | Speci | |
| | 3 M WOMEN 4 DIVOICES | | | | | | | | | | | WHITE |
| Ĕ | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a, DE | CEDENT'S U | SUAL OCCU | PATION | rina | 16b. KIN | O OF BUS | INESS/INI | DUSTRY | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 +) | life. | Do NOT use | retired.) | most of work | arry. | | | | | |
| 틸 | 8 | | | HON | IEMAKE | ìR | | _ | OM | N HC | MF: | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | THER'S NAM | AE (First, Middle | | | 7.11. | |
| | JAMES MARTIN | | | | | THE STATE OF | | TTA WA | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 101 | MAIL INO A | DODESS /Sh | | | oute Number, C | | | | |
| 2 | MARILYN DIMARCO | | 1 | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION | | | | | | r., s | EABROC | | | _ | 20706 |
| | 1 by Burlel 2 Cremetion 3 Remo | oval from State | 20b. PLACE / cemetery, cra | NDDATE OF matory or oth | DISPOSITION or place) | N (Name of | | DATE | 20c. LOC | ATION — | City or To | wn, State |
| | 4 Donetion 5 Other (Specify) | | REST | HAVEN | | | | 0/96 | HA | GERS' | NWOT | , MARYLAND |
| | 21. SIGNATURE DE FUNERAL SERVICE LIC | | | | | E AND ADDR | | | 7606 | 014 | Mat | ional Pike |
| | - and III KA | Me Par | al M. | Dean | BAS | r fune | ERAL I | HE NVIH: | | | | D 21713 |
| | 23. PART I. Enter the diseases, or c | omplications that ca | used the de | ath. Do no | t enter the | mode of d | dan euch | an conding | BOOTIS | SDOT | O, M | |
| 1 | anock, or neart tellure. | Liat only one cause | on each ilne | | | | ring, addit | aa cardige | or reapir | atory at | reat, | Approximata Intarval Between |
| | IMMEDIATE CAUSE (Final disease or condition | Mar | 10 | | 00.4 | . / | 1 | 11 | 14.11 | ^ | | Onset and Death |
| | resulting in death) | MALIG. | NANT | CA | KUIA | Cr | KKH | YTH | mi | H | | 10 MIN |
| | | M War of Or | AS A CONSEC | DUENCE OF) | | `A = /- | | | | | | |
| CERTIFICATION | Sequentially list conditions, | MYDCAI | AS A CONSEC | | LNH | HKCI | 100 | | | | | 1 HOUR |
| F | If any, leading to immediate cause. Enter UNDERLYING | C C C A L | OD U | OENCE OF): | | 7 | 100 | N/T | | | | |
| | CAUSE (Disease or Injury | COKONI | AS A CONSEC | ITK | IEN | | 71261 | 775 | | | | |
| | that initiated aventa resulting in death) LAST | DOE TO (ON | AS A CONSEC | DUENCE OF): | | | | | | | | |
| | | i | | | | | | | | | | |
| - 11 | PART II. Other algnificant conditions | n contributing to dea | th but not n | eauiting in | the under | ving cause | alven in F | Part I 24a | WAS AN A | UITOBEV | Tan | WERE AUTOPSY FINDINGS |
| DICAL | | REBRAL | | NFA | | ying cause | Arean in c | 246. | PERFOR | | 240. | AVAILABLE PRIOR TO |
| | MICE TITLE | -CDIVIC | - | NEAL | VC 1> | | | t 🗆 | YES 2 | □ NO | | OF DEATH? |
| Σ∥ | | | | | | | | _ | | | | 1 TES 2 NO |
| z I | DID TOBACCO USE CONTR | RIBUTE TO CAUS | E OF DEA | TH YES | ☐ NO | □ UN | CERTAIN | | | | | X+ |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26, PLAC | | (Check only | one) | | | | | | |
| <u> </u> | t 🗆 YES 2 🗀 NO | t Inpatient 2 ER | Outpatient 3 | □ DOA | Nursing | Home 5 🗆 R | eeldence 8 | Other (Spe | ecify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF INJU | JRY | 28b. TIME | OF 28c. | INJURY AT | | 28d. DESCRIB | E HOW IN | JURY OC | CURED | |
| > | 1 Natural 5 Pending Investigation | (MORII, Day, R | our) | INJUI | | WORK? | □ ND | | | | | |
| <u>" </u> | 3 Suleide | 28e. PLACE OF IN. | JURY — At hor | ne, farm, str | eet, tectory, | office | - | 281. LOCATION | N (Street or | nd Number | or Rural B | loute Number |
| | 4 Homicide B Could not be | building, atc. | (Specify) | | • | | | City or Tow | vn, State) | | | |
| 9 | 29e. CERTIFIER | | | | _ | _ | | | | | | |
| <u> </u> | (Check only | CIAN: To the best of my i | | | | | | | | | | |
| COMPLE | 2 MEDICAL EXAMINER | R: On the basis of examin | nation end/or is | nveatigation, | In my opinio | n, death occu | red at the ti | lme, date end | place, end | due to th | ne ceuse(e | end menner se stated. |
| | 296. SIGNATURE AND THE OF CERTIFIER | 1.1 | | | | 29c. LIC | ENSE NUME | BER | | 29d. DAT | E SIONED | (Month, Day, Year) |
| N (12) 1 (12) 1 (13) N 337M) 1-76-91 | | | | | | | | | 2-96 | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF | F DEATH (ITEN | 1 27) (Type, P | rint) | 10. | | | | - 1 | | - 10 |
| | TED E. HOL | the same of the sa | M . | | ص ح | VI | R. | Boom | KPA | DO | Λ | 10 |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S | NATURE | 0000 | | _ < | 100 | raur | 7770 | FU. | // | Ψ) |
| | JAN 3 1 1996 A | LANCO CONTRACTOR | April 1 | | | | | | | | | |
| | U | | | | | | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene 96 03799

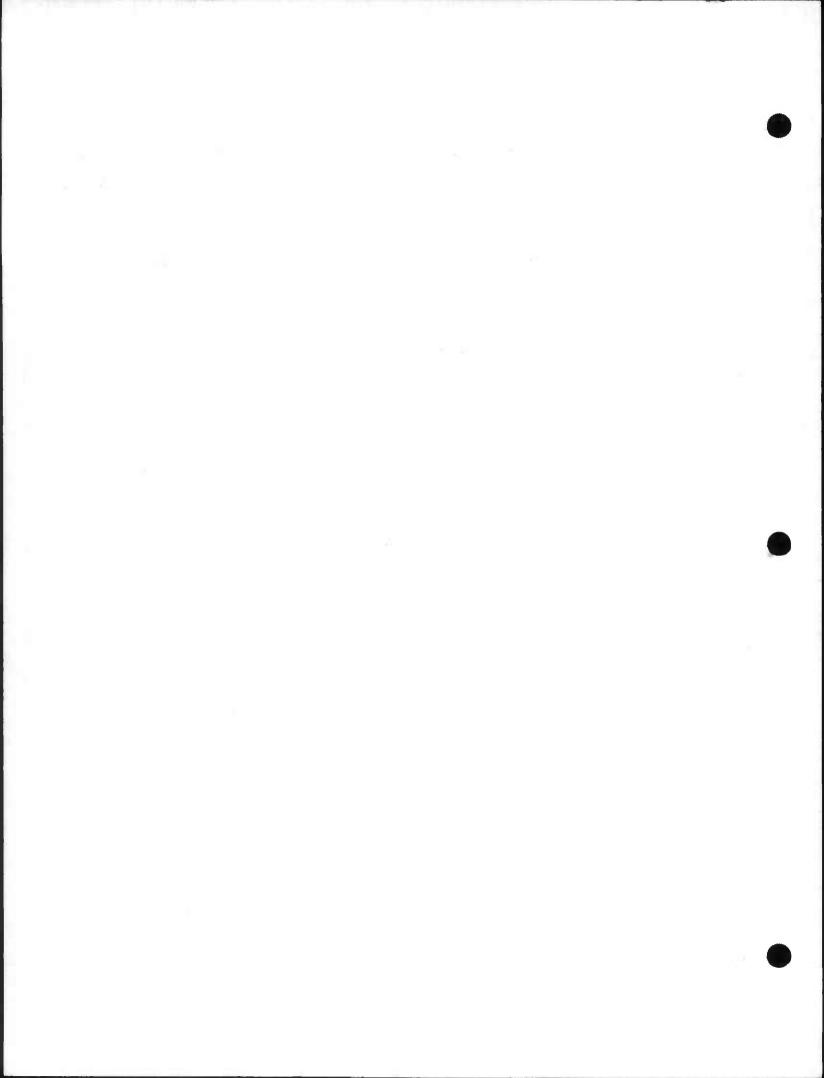
| | | | | | | Ce | ertificate of | Death | Re | g. No. | | | | |
|------------|--|--|---|--|--------------------|---------------|---|---|---------------------------------------|------------------|----------------------------------|--|--|--|
| | | | 1. Decedent's Neme (First, Middle | a, Last) | | | | | 2. Dete of Deeti Month | h | Veer | 3. Time of Death | | |
| | Physici /Medi | | Ray Ell | is Nigh | | | | | OJan | 28 | 96 | 8:00 PM | | |
| | Examir | | 4a. Facility Neme (If not institution | | r) | | | 4b. City, Town, or | Location of Death | 4c. County | | | | |
| | | | Washington Cour | tv Hospita | 1 | | | Hagersto | own | Washi | ngto | n | | |
| Т | Funeral | Г | 5. Sociel Security Number | 6. Sex 7. / | | last birthday | Months Dev | r If Under 24 Hrs | 8. Dete of Birth | | | lece (State or Foreign | | |
| E) | Director | | 577-10-3547 Usuel Residence of Decedent | 1 M 2 □ F | 82 | Yrs. | MOIRIS Dey | S PROUIS MIII | Sept. 28 | | | yland | | |
| | yland | | 10e. Stele 10b. County 10c. City, Town or Location | | | | | | | | | 0d. Inside City Limits | | |
| | Mar 1 | to | Maryland Wash | nington | W: | illian | nsport | | | | | 1 ☐ Yes 2 ☑ No | | |
| | r 28 | Director | 10e. Street end Number | - 0 | | | 10f. Zip Code | | 10 | Og. Citizen of V | Vhet Cour | ntry? | | |
| | h wit | 0 10 | 16710 Virginia Avenue 21795 U.S.A. | | | | | | | | Α. | | | |
| 20 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiena. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanance mant be notified at | by Funeral | 11. Marital Status 1 □ Never Merried 2 ☑ Merr 3 □ Widowed 4 □ Divorced | 12. Wes Deceder Armed Force ied 1 Yes 2 If Yes, Give Yeer or Detes | s? XNo | ,S. 13 | . Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No | Hispenic Origin? (S ben, Mexican, Puer Specify: | Specify Yes or No- to Rican, etc.) | Bled | e - Americ k, White, White | | | |
| ŏ | 2 hou | | 15. Decedent | | | 16e. Dec | edent's Usuel Occ | upetion | | 16b. Kind of Bu | isiness/înc | dustry | | |
| 21215-0020 | n n n | Completed | (Specify only highes | f grade completed) | · F · \ | (Giv | e kind of work don DO NOT use retir | e duning most of wo | nking | | | , | | |
| 2 | d with | E | Elementery/Secondary (0-12) | College (1-4o | (3+) | I | river | | , | Various | cor | porations | | |
| | i Hyg other | BeC | 17. Fether's Neme (First, Middle, | | | | | 18. Mother's Ne | me (First, Middle, M | | | | | |
| Maryland | lenta ked ked | To B | Charles Beaver | Nigh | | | | Arera | Virginia | Neikir | k | | | |
| ary | shou ond N | - | 19a. Informent's Neme/Reletions | - | | 19b. Mai | ling Address (Stree | | ural Route Number, | | | Code) | | |
| | alth a 27 le | | Evelyn Nigh | (Wife) | | 16710 |) Virgini | a Avenue | William: | sport, | Mary | land 21795 | | |
| altimore, | f He f He ftern othe | | 20e. Method of Disposition | | | Plece of Disp | position (Name of ematory or other p | lenel | Dete 2 | 20c. Location - | City or To | wn, Stete | | |
| 9 | | | 1 🖾 Buriel 2 ☐ Cremetlon 4 ☐ Donetion 5 ☐ Other (S) | | 0 | , . | | 1 Park 1 | -31-96 | Willian | cnor | t Md | | |
| = | 2525 | | 21. Signeture of Funeral Service | | GIE | | 22. Name end Add | | | | | c, m. | | |
| m | permi Depar Impor any ir | | 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 | | | | | | | | | | | |
| | _ | 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| | Physician | | shock, or heert feilure. List | | | | | | | 741, | | Approximete Interval Between Onset end Deeth | | |
| | /Medical Examiner | | Immediete Cause (Finel diseese or condition resulting in death) | e. Ce | reb | ral | Hern | iation | | | | 20 hours | | |
| | | Je. | | - | Due to (d | or es e cons | equenca or): | dono ma | 0.00 | | 1 | zo hours | | |
| | eath certificata be axecuted attending physician and for use es tha burial-transit | Examiner | Immediate Cause (Final disease or condition resulting in death) e. Cerebral Herniation Due to (or es e consequenca of): Intracuebral Hemonhage Due to (or es e consequence of): | | | | | | | | 1 | CO NOWIS | | |
| o, | an ar | | Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying | | | | | | | | | | | |
| 68760, | ta be ysici | edical | Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): | | | | | | | | | | | |
| | tifica ng ph es ti | Med | resulting in deeth) Lest | | | | | | | | İ | | | |
| XO | tha death certificata be axecuted y tha attending physician and sched for use as tha burial-transit | an | | d | | | | | | | 1 | | | |
| .0 | deal na att | sici | Pert II. Other significant condition | ns contributing to death | but not res | ulting in the | underlying cause (| iven In Pert I. | 23b. Did to | becco use co | ntribute to | the cause of death? | | |
| 0.0 | es that the death igned by the atter be deteched for u | / Physician/ | hypertensi | on, an | as it. | oau' | notion | | 1 □ Y | s 2□ No | 3 🗆 Pro | bably 4 Onknown | | |
| ds, | 8 50 | d by | | | | 3 | | | 24e. Wes sr | n eutopsy | 24b. W | ere autopsy findings | | |
| Ö | v require been si should | ete | | | | | | | perform | | CO | eileble prior to impletion of ceuse | | |
| Record | a lev has | Completed | | | | | | | | | | desth? | | |
| _ | ician: Tha i cartificate ha rector, paga | | | | | | | | 1□ Ye | | 1. | Yes 2 No | | |
| Vita | ysician: s cartific director, | Be | 25. Was case referred to medical exeminer? | Hospitel: | | | _ [0 | ther | eth (Check only on | | | | | |
| ō | 문 문 등 | : To | 1 ☐ Yes 2 ☑ No 27. Menner of Death | 1 Minpa | | ER/Outpetic | MIK JLI DON | 4 Li Nuising | Home 5 ☐ Reside 28d. Describe ho | | | N) | | |
| no | After fune | tion | 1 Naturel 5 ☐ Pendin | | ay Year) | Injury | W | ork? □Yes 2□No | 200. Describe no | W aljuly Coods | 00 | | | |
| S | aat tha | lica | 3 ☐ Suicide 6 ☐ Could r | ot be 200 Dines of I | niuny - At he | ome form s | treet, fectory, office | | 28f. Location (St | reet and Numb | er or Rure | al Route Number | | |
| Division | P St. P | Certification: | 4 ☐ HomicIde determ | building, | etc. (Specif | y) | arout, rostory, only | | City or Town | | | | | |
| | To the Hospital or Alt within 24 hours after of To the Funeral Direct completely filled in by | | 29e. Certifler 1 € Certifyin | g Physicisn: To the bes | t of my kno | wledge, dee | th occurred et the | time, dete end plec | e, end due to the ce | euse(s) end me | nner es s | teted. | | |
| | Parents | edical | (Check only 2 Medical I | Examinar: On the basis end menner | of exemine steted. | tion end/or I | nvestigetion, in my | opinion, deeth occ | urred et the time, de | ete end piece, | and due to | the ceuse(s) | | |
| | To th To th Somp | Me | 29b. Signeture end title of certifier | | X 5750 | | 29c. Lice | nse number | 25 | 9d. Date signe | d (Month, | Dey, Year) | | |
| | | | MIL D Ve | Hy! | 100 | JAN | D | 45936 | | 1/201 | 96 | | | |
| | : | | 30. Name and eddress of person | who completed cause of | deeth/ill | 23a) (Tvp | | 77770 | | 100/ | , – | | | |
| | | | | retua R | . 11 | | persta | wn. M | anland | / 217 | 40 | | | |
| | | | 27 27 28 20 20 20 20 20 20 20 20 20 20 20 20 20 | | - | | 0 | | 1 | - | | | | |

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| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | MENTAL HYG | | | | | | |
|---|---|--|---------------------|--|------------------------------|---|--------------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | it) | - | 11 | | 2. DATE OF DEAT | н | 3. TIME OF DEATH | | | | |
| | HOWARD J. NIC | HOLS | | Nich | 10/5 | January | | /EAR /0/0 M | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (Ir | yrs. last birthday) | IF UNDER 1 YEAR | BIRTHPLACE (State or Foreign | | | | | | | |
| | 222-10-6526 | Country) Md. | | | | | | | | | | |
| œ | 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | | |
| DIRECTOR | PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION 100. | | | | | | | | | | | |
| DIRE | Md. Wico | | | 10d. INSIDE CITY LIMITS? XX YES 2 \(\text{NO} \) NO | | | | | | | | |
| A | 10e. STREET AND NUMBER | | | 10f. | ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? | | | | |
| FUNERAL | 411 Elizabeth S | t. | | | 21875 | | USA | | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? XX YES | U.S. ARMED | | | HC ORIGIN? (Specifin, Puerto Ricen, atc | | I. RACE — American Indian, Black, White, stc. | | | | |
| ВУ | 1 Never Merried 2 Merried 3 X Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 - YES | | | , | Specify. White | | | | |
| | 15. DECEDENT'S E | WWII & Kore | 16e. DECEDENT'S | USUAL OCCUPATIO | NAI | 16P KIND OF | BUSINESS/INOUS | | | | | |
| ETE | (Specify only highest gri | ade completed) | | ork done during mos | | 100. KIND OF | BUSINESS/INDU | otni | | | | |
| P | 10 | College (1-4 or 5+) | Cook | | | U.S. | Navy | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Me | | | | | | |
| ш | Howard B. Nicho | ls | | | Mildre | d Johnso | n Nicho | ls | | | | |
| B | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | nd Number or Rural | Route Number, City o | Town, State, Zip C | ode) | | | | |
| 2 | David Brent Nic | hols | Rt. 5 | Box 13 | 0 Seafor | d, De. 1 | 9973 | | | | | |
| | 20e. METHOD OF DISPOSITION 1 [X] Burlel 2 Cremetion 3 Re | | PLACE AND DATE O | | | | LOCATION — CI | | | | | |
| | 4 🗋 Donetion 5 🗆 Other (Specify) _ | St | Stephe | | | | elmar, 1 | De. | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | , | | t Funera | 1 Home, | Inc. | | | | | |
| | William 1 | 1. Stort | | | | St. Delm | | 19940 | | | | |
| | 23. PART I. Enter the diseases, o | or complications that coused re. List only one couse on ee | the death. Do n | | | | | it, Approximate | | | | |
| | IMMEDIATE CAUSE (Final | e. List only one couse on ee | 0 | 11 | 10 | 2 () | ^ | interval Between Onset and Death | | | | |
| | disesse or condition resulting in death) | · Couge | stwe | Hear | y ta | riles | e | | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE OF |): / · · | | | | | | | | |
| Z | Sequentially list conditions, | b | | | | | | | | | | |
| PA | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF | ·); | | | | | | | | |
| 윤 | CAUSE (Disease or Injury that initiated events | C. DUE TO (OR AS A | CONSEDUENCE OF | j: | | | | | | | | |
| RTIFICATION | resulting in death) LAST | | | | | Ł | | , | | | | |
| 핑 | | _ G. | | | | | | | | | | |
| k | PART II. Other aignificant conditi | ions contributing to deeth bu | it not resulting i | n the underlying | g csuse given in | | S AN AUTOPSY REORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | |
| EDIC | | | | | | 1 🗆 YE | S 2 NO | OF DEATH? | | | | |
| Σ | DID TODA CCO LICE COA | ITDIDLITE TO CALICE OF | E DE ATLL VE | CENOE | LINIGEDEAU | | | 1 TES 2 NO | | | | |
| HYSICIAN: | DID TOBACCO USE CON | | OLAIH YE | | UNCERTAI | иП | | | | | | |
| 120 | EXAMINER? | HOSPITAL: | | OTHER: | | | | | | | | |
| 148 | 27. MANNER OF DEATH | 1 V Inpatient 2 - ER/Outpa | 28b. TIMI | | | 6 Other (Specify 28d, DESCRIBE H | | RED | | | | |
| 0 | 1 Natural 5 Pending | (Month, Day, Year) | INJ | URY WO | RK? /ES 2 NO | | | | | | | |
| ВУ | 2 Accident Investigatio | 28e. PLACE OF INJURY | — At home, ferm, s | treet, factory, office | • | 261. LOCATION (S | reet and Number of | Rural Route Number, | | | | |
| U 4 Homicide determined building, etc. (Specify) | | | | | | | | | | | | |
| 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner se stated. | | | | | | | | | | | | |
| COMPL | const. Orny | INER: On the beele of examination | | | | | | | | | | |
| 1 296-SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | | | |
| 8 | (Seni rounin | H Me | els/ | | 3074 | 3 | b // | 23/95 | | | | |
| 유 | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF DEA | N | Print) | | _ | -/ | - / 14 | | | | |
| | | ever, mp | ZUINCIL | + 4001/37 | 513. | 3A43BU | 14, m | 21801 | | | | |
| | 31. DATE FILED (Month) AN 25 | 1996 REGISTRATE | dia Barla | 4 | | / | | | | | | |

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| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | | | | DEATH AND | MENT | AL HYGIENI REG. NO. | | | | |
|--|---|---|--|-----------|---------------------------------------|-------------------------------|--|-----------------------------|---|--|---------|---|--|
| | DECEDENT'S NAME (First, Middle, Last) BEATRICE | М. | M. OAKS | | | | | January 29 1996 5:58 P M | | | | | |
| | 4. SOCIAL SECURITY NUMBER 173-07-7235 | 5. SEX 6. A | SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE | | | | E OF BIRTH | | & BIRTH | PLACE (State or Foreign | | | |
| 5 | e. FACILITY NAME (If not institution, give str Regency Nursing & | | ter | | | | OR LOCATION OF D | EATH | | ec cour Prin | | George's | |
| DIMECTOR | RESIDENCE OF DECEDENT t0a, STATE 10b, COUNTY | | 19 | 10c. CITY | r. TOWN O | R LOCAT | TION | | | tod. INSIDE CITY | | | |
| | Maryland Prince | e George's | | Fo | rest | vill | .e | | | | | t YES 24 NO | |
| UNEWAL | 2408 Wintergreen A | Ave | | | | 101 | 20747 | 7 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 27 | 11. MARITAL STATUS t Never Married 2 Married 3 Middowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1XXXY IF YES, GIVE WAR O | ES 2 NO | D | 13. 1 | MAS DEC 1 yes, sp 1 YES | ENDENT OF HISPA ecity Cuben, Mexico 2 TYNO Special | NIC ORIG nn, Puer ly: | GIN? (Specify Yea to Rican, atc.) | or No— | Blac | E — American Indian, k, White, etc. White | |
| LEIEU | ts. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | life. Do | kind of w | USUAL Of vork done of retired.) | CCUPATIO | ON ist of working | | 6b. KIND OF BUS | | | | |
| COMPLE | 12th 17. FATHER'S NAME (First, Middle, Last) | | WAF | _ | | | 10 MOTHED'S N | | t, Middle, Malden | | Force | | |
| 2 C | Walter Mosher | | | | | | Rhoda I | avi | na Osgo | od | | | |
| 2 | too. Informant's name (Type/Print) Ronald G. Wood | | | | | | Lane, E | | | | | 9 | |
| | 20e_METHOD OF DISPOSITION 2\times Burlel 2 \ Cremation 3 \ Remo 4 \ Donation 5 \ Other (Specify) | oval from State | 20b. PLACE AND ATTING | DATE O | of DISPOS | ition (Na iona | Feb 8 | 3,19 ery | | | | wn, State irginia | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICE | 5it | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Ho 6633 Old Alexander Ferry Rd., C | | | | | | | Home | e, Inc. | | |
| CERTIFICATION | shock, Dr heart fellure. Liet only one ceuse on each line. | | | | | | | | | Approximate Interval Between Onast and Death | | | |
| 2 | PART II. Other significent condition | a contributing to dear | th but not ree | ulting | In the ur | nderlyln | g ceuse given in | Part I. | | | 241 | . WERE AUTOPSY FINDINGS | |
| MEDICA | | | | | | | | | PERFOR | | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| 2 | DID TOBACCO USE CONTI | RIBUTE TO CAUSI | | | S 🔲 I | | | N 🗆 | | | | | |
| 200 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE | | OTHE | a : | | • 🗆 • | 40. 41. | | | | |
| Y PHYSICIAN: | 27. MANNER OF DEATH Natural 5 Pending | 28a. DATE OF INJU (Month, Day, Ye | RY : | 28b. TIM | _ | 28c. IN. | JURY AT DRK? YES 2 NO | | DESCRIBE HOW I | NJURY OC | CURED | | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be determined | 28e. PLACE OF INJ building, etc. | | | | | | 281. L | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSION 2 MEDICAL EXAMINE | CIAN: To the best of my in R: On the bests of examin | | | | | | | | | | a) and manner as stated. | |
| O BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | | > M | . つ | | | 29c. LICENSE NU | | | 29d. DAT | - | (Month, Day, Year) | |
| <u> </u> | 30. NAME AND ADDRESS OF PERSON WHO | ngston k | 59. # | 10 | 1 + | 7+. | Washin | gto | nmd | 2 | 07 | 44 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 1701 Livings ton Rd. #101 Ft. Washington Md. 20744 31. DATE FILED (Month, Day, Voar) 1AN 3 0 1996 Julia d'Audien Redell | | | | | | | | | | | | | |



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible

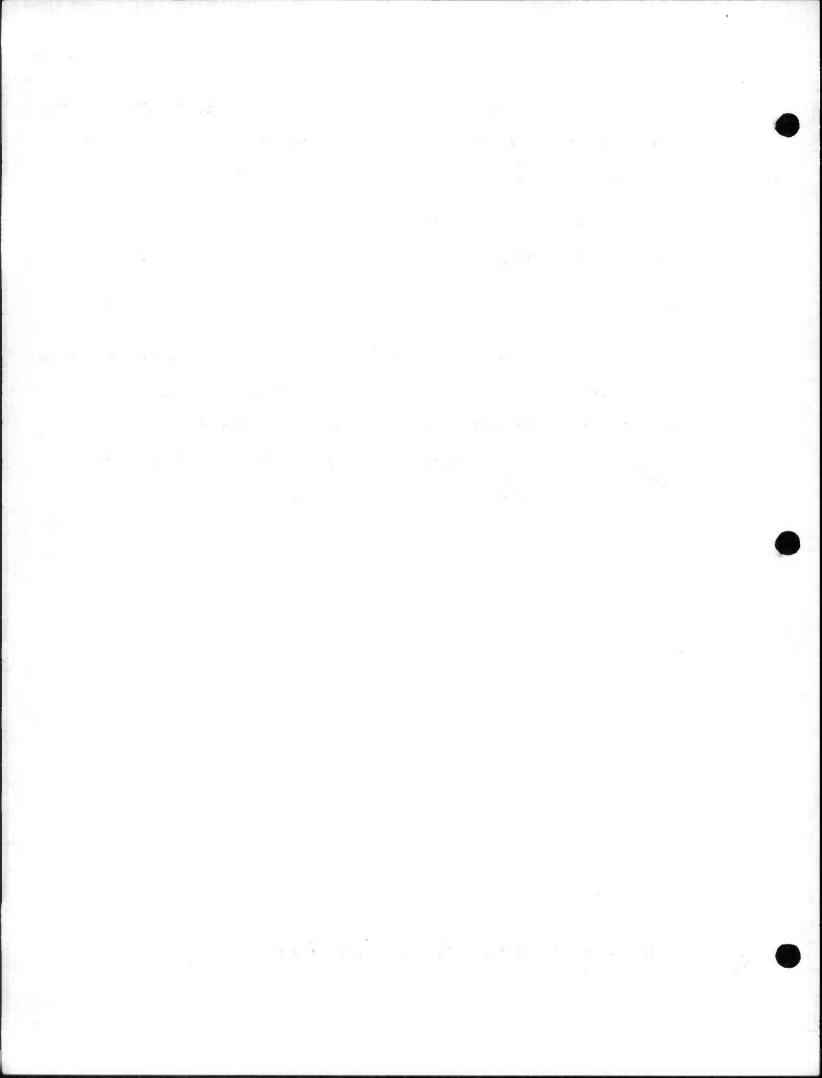
State of Maryland / Department of Health and Mental Hygiene 96 Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Dsta of Death 3. Time of Death Month **Physician** Doris Prout Ogden 20 1996 9:00 PM January /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Solomons Nursing Center Solomons 5 4 1 Calvert 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours Yrs. Director 218-12-2961 MD Usual Rasidanca of Decedant the Maryland 10a Stata 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show mant be notified at 1 ☐ Yas 2 X No Director Calvert Owings 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 1775 West Mt. Harmony Road U.S.A. 20736 Funeral 12. Was Decedent Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanto Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Yas 2 🖾 No 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ 3 ₺ Widowed 4 Divorced white Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 4 Owner/Operator Advertising Company and Mental Hygie Is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be Carrow Tolson Prout Mary Alberta Merrick 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Heelth Important: If Itam 27 I Thaddeus E. Prout, MD 3808 Fenchurch Road Baltimore, MD Brother 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donafjon 5 ☐ Othar (Specify) Dulaney Valley Mem Grdns 1-26-96 Timonium, MD 21. Signature of Funeral Service License 22. Nama and Addrass of Facility Rausch Funeral Home, PA Owings, MD 20736 23a. Part1. Enter the diebase, or shock, or heart failure. List in this causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, Approximata Intarval Between Onsat and Death **Physiclan** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated evants resulting in death) Lsst physician er s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detect 1 Tes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to Brain Syndrom Completed 24a. Was an sutopsy performed? completion of cause of death? has he 2 2 10 No 1 Yas 2 No certificate director, Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) 20 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Medical Certification: To 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manney of Death 28d. Dascribe how injury occurred 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Panding after death.

Director: Aft
d in by the fur 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida within 24 hours aft To the Funeral Di-completely filled in To the Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar 29b. Signature and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of parson who complated causa of death (Itam 2/11) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Julia Davidson Rardall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legisla

| | | | | State of Ma | | / Depa | | Health and | | | - | 3803 |
|------------|--|----------------|--|--|--------------|-------------------------|--|-----------------------------|--|-------------------------|------------------|---------------------------------|
| п | Physic | ian | Decedent's Neme (First, Middle, Last | | | | | 2. Dete of D Month | eath Day | Yeer | 3. Time of Death | |
| | /Medi | | BETTY MAE | | | O'DO | ONNELL | | Jan. | | 1996 | 11:50 p |
| 7 | Examir | | 4e. Fecility Neme (If not institution, give | | | | | 4b. City, Town, or | Location of Dea | ith 4c. Cou | inty of Deat | h |
| | | | Memorial Hospi | | sto | | | Easto | | | albot | |
| | Funeral | | 5. Sociel Security Number 6. Se | х 7. Age | (In yrs. las | st birthday) | If Under 1 Year Months Deys | Hours Min | | irth Dey, Year) | 9. Birt | hplace (Stete or Foreign |
| | Director | | 218-24-5825 Usuel Residence of Decedent | | | Yrs. | | | JUL. 7 | ,1929 | MA | RYLAND |
| | hend wo | | 10a. State 10b. County | | 10c. City, | Town or Lo | ocation | | | | | 10d. Inside City Limits |
| | with the Merylend a or 28a-f show the notified at | to | MD OHEEN | ANNE'S | CD | A CONT | VILLE | | | | | 1 Yes 2 No |
| | r 28a | Director | 10e. Street and Number | AUNE 5 | GIC | ASON | 10f. Zlp Code | | | 10g. Citizen | of What Co | untry? |
| | 23a o | a D | 626 CHESTER RI | VER BEACE | RO. | AD | 216 | 38 | | U | SA | |
| | 9 2 9 | Funeral | 11. Marital Status | 12. Was Decedent Ev Armed Forces? | er in U,S. | 13. | Wes Decedent of I | lispanic Origin? (| Specify Yes or N | 14.1 | | rican Indian, |
| 0 | urs after of ther alt, or ther | | 1 Never Merried 2 Married | 1 Yes 2 No If Yes, Give Yeer or Detes: | ı | | 1 ☐ Yes 2 ☐ No | Specify: | to riican, etc.) | | Bleck, White | |
| Š | ural', | d by | 3 Widowed 4 □ Divorcad | Year or Detes: | | | 7 166 2 X | ореспу. | | Spe | city: | WHITE |
| 0200-91212 | 72 hours netural', | Completed | 15. Decedent's Edu (Specify only highest grad | ication le <i>completed)</i> | | 16a. Deced (Give | dent's Usuel Occup kind of work done | pation during most of wo | orking | 16b. Kind o | f Business/ | Industry |
| 7 | within ene. | dw | Elementery/Secondery (0-12) | College (1-4or 5+ | | | DO NOT use retire | · | מי | DOC | mat (| SYSTEM |
| - | 005 | | 17. Fether's Neme (First, Middle, Last) | | | KUK | AL MAIL | | me (First, Middl | | | SISIEM |
| yland | 8 <u>a</u> b > | To Be | NATHAN EDWARD | MORRIS | | | | | TH MAE | | | |
| ary | A DEE | F | 19e. Informent's Neme/Reletionship (7) | | | 19b, Mellin | ng Address (Street | | | | | Zip Code) |
| Σ | Ta Signary | | GEORGE M. O'DO | NNELL | | | | | | | | NVILLE, MD |
| ore, | 8 5 2 | | 20e. Method of Disposition | | 20b. Pled | ca of Dispo | sition (Name of metory or other pla | ce) | Date | 20c. Location | on - City or | Town, Stete |
| altimor | permit. Pages Department of I Important: If its any injury or o | | 1 Burial 2 Cremetion 3 F 4 Donetion 5 Other (Specify) | Removal from State | | | ILLE CE | | 1-25 | STEVE | NSVI | LLE, MD |
| a | Departr Departr Imports any Injk | | 21. Signature of Funeral Service Licens | 00 | | | . Name end Addre | | | | | |
| מ | 205 2 9 | | 1040 3 ms | a. ERO |) | ESP 2 | EWNAM F | UNERAL | HOME, | P.A. | | 21.601 |
| | | Г | 23a. Part1. Enter the diseese, or complishock, or heert feilure. List only or | icetions thet caused the | ne deeth. | Do not ent | er the mode of dyi | ng, such es cardie | c or respiretory | errest, | N, MU | Approximate Interval Between |
| | Physician | | | | | | | | | | | Onset end Deeth |
| | /Medical Examiner | | Immediate Ceuse (Finel disease or condition resulting in deeth) | Long | 3 | and | es | | | | | Days |
| | | <u></u> | resulting in deeting | ס | ue to (or e | s a consec | quence of): | | | | | |
| | ted nsit | Examiner | | D. —- | | | • | | | | 1 | |
| 3 | te be executed ysician end se burial-transit | Exal | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying | Di | ue to (or e | s e conseq | uence of): | | | | į | |
| 00/ | sicial burn | ह | Cause (Disease or Injury thet initieted events | 3 | 10 to /or o | | | | | | | |
| 00 | certificate iding phys | B | resulting in death) Last | Di | 10 (01 9) | s a conseq | uence or): | | | | | |
| ŏ | andin use | S | | d | | | | | | | | |
| 0 | death e atter ed for u | sicie | Part II. Other significant conditions cor | ntributing to death but | not resulti | ng In the u | nderlying cause gh | ven in Pert i. | 23b. Did | i tobacco uss | contribute | to the cause of death? |
| | w requires that the death certificets been signed by the attending phy should be detached for use as th | Physician/M | Inheren Ac | DD inter | | | | | 10 | Yes 2 N | o 3 Pr | robably Wunknown |
| ń | es the | by | 100gcco No | ear la | <u> </u> | | | | | | | |
| Splos | requires | Completed | Dollegorati | an- | | | | | 24e. We per | s en autopsy formed? | | Were autopsy findings |
| Š | 2 58 8 | nple | , T | 1 - | | Λ | | | | | | completion of cause of death? |
| 0 | E se se | | 000110017 | act R | tree | 240 | | | 1□ | Yes 2 N |) | 1 ☐ Yes 2 ☐ No |
| = | Physician: The rists certificate and director, pag | Be | 25. Wes case referred to medical examiner? | fospitel: | | | Oth | 201 | eth (Check only | | | |
| 5 | Phys ral di | To | 1 ☐ Yes ZX No 27. Menner of Deeth | 28a. Dete of Injury | | VOutpatien 8b. Time of | IL SLI DOA | 4 Li Nursing i | Home 5 Res | how Injury oc | | city) |
| 5 | ding h. After fune | tion | Neturel 5 Pending 2 Accident Investigation | (Month, Day) | (ear) | Injury | Wo | rk? Yes 2 □ No | 200. 0000100 | now injury oc | 001160 | |
| NISION | or Attending Phater death. Director: After this in by the funeral | fica | 3 Suicide 6 Could not be | 28e. Plece of injury | / - At home | e, farm, str | | | | | mber or Ru | ıral Route Number, |
| 5 | s afte | Certification: | 4 Homicide | building, etc. | (Specify) | | | | | own, State) | | |
| | To the Hospital or Attending Phys within 24 bours after death. To the Funeral Director: After this completely filled in by the funeral di | edical C | (Check only 2 Medical Examin | sician: To the best of e | kaminetion | edge, deeth | occurred et the time time occurred et the time | me, dete end plec | a, end due to the urred et the time | e ceuse(s) end | manner es | steted. to the cause(s) |
| | thin 2 the mplei | Med | one) 29b. Signeture and title of certifier | end menner stete | d. | | 29c. Licens | | | | | |
| | 5 × 5 8 | _ | 200. Signitude of Cartina | 1 Luna | 5 | |) CI | 2001 | - | 29d. Date sig | 777 | JOL |
| | | | 30 Name and address of | won | U | 2a) /T | Dried) | 2005 | , | Ot. | , | 770 |
| | | | 30. Neme end eddress of person who co | иприесва саuse от dee | m mem 2 | 361 (IVD6. | rnnt) | | | | | |

State Registrar 31. Dete filed (Month, Dey, Year)

JAN 2 4 1996

32. Registrer's Signeture
Jahra Shuthar Rawall,

MICHAEL LEES, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601

Definition of the second of th

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/Medical Examiner Examiner burial-transit physicien certificate be Physician/Medical the 98 esn requires thet the death for the signed by the by Completed certificate hes director Be 2 After this funeral Certification: or Attending efter deeth. Hospital or Attent 24 hours efter de
 Funerel Directo

Funeral

Director

Peges 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mentel Hyglene.

Inst. If Item 27 Is marked other than "natural", or Items 23s or 28s-4 show any or other transmit as northed show may or other transmits avent, in Medical Exertine man be northed as

important: If it any injury or o

Physician

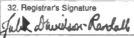
pemit. Pege Department

Certificate of Death Amended #1, 1/30/96, JW, Montgomery Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Maria Sheilah Agudelo Orendain 3. Time of Death **Physician** SHEHAH A OFENDAIN 1104 AM JAN 1996 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Dey, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1□M 2\ F Yrs 28 Philippines Not Applicable May 4, 1967 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 11205 Angus Place 20854 Philippines Funeral 12. Was Decedent Ever In U,S. Armad Forces? 1 ☐ Yas 2 ᡚ No If Yas, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Filipino 1 X Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest greda complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baby Sitter 4 Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Romeo Orendain Nilda Agudelo 19a. Informant'e Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace T. Gaerlan / friend 4237 S. 36th St., Arlington, Virginia 22206 20b. Piaca of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 ARemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Greenhills Memorial Park 2/1/96 Cagayan de Oro, Philipp. 21. Signatura of Funeral Sarvice Licensee 22. Nama and Address of Facility
De Vol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or iteart failure. List only one cause on each line. Approximata tnterval Between Onsat and Death Immediate Cause (Final diseasa or condition resulting in death) . Shock Acute respiratory distress Syndrome 24 hours Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hemoreii toreum Due to (or as a consequenca of): ECTOPIC Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown UNCHOWN 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 No 25. Was case refarred to medical 28. Place of Death (Check only one) THYES DO NO RC Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 27. Mail er of Death 28a. Date of Injury Month, Pay Ye 28b. Time of tnjury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a, Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Heren



10215 Ferrowco0

#405 BeTHSDa, Marylmin 20878

To the Hosp within 24 ho To the Fune completely f

BALTIMORE, MARYLAND 21215-0020

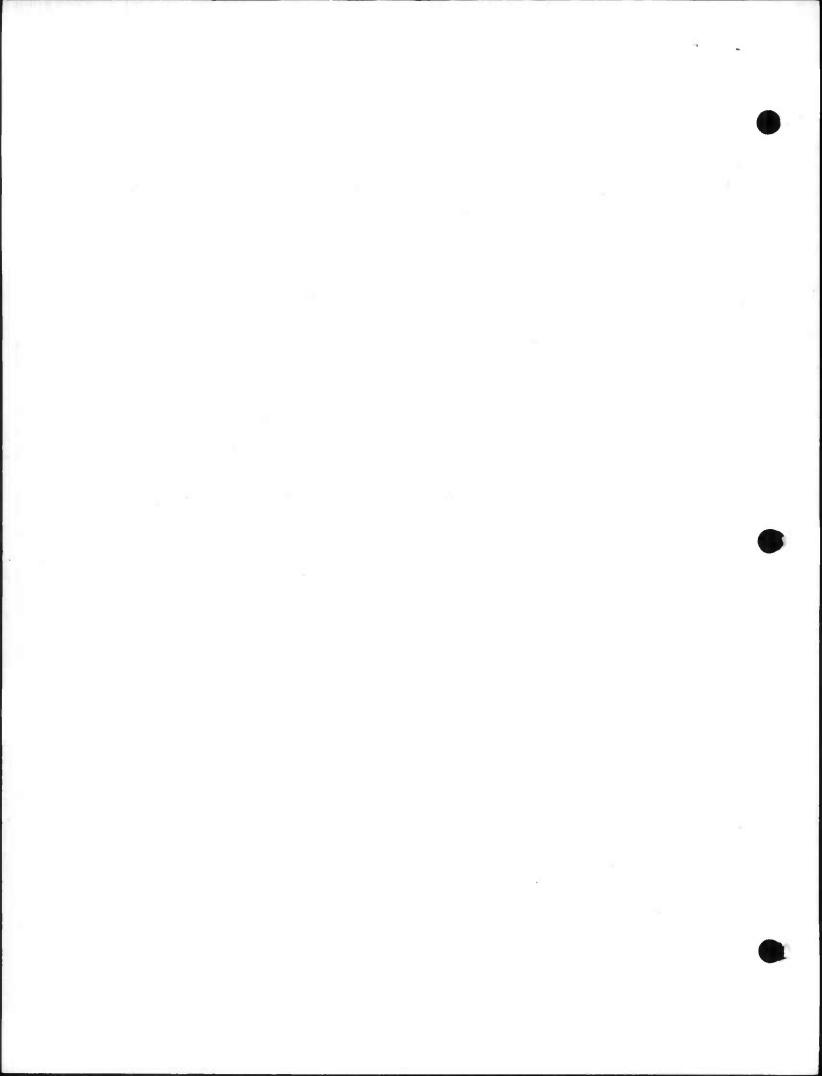
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
|---|--|---|-------------------------|-------------------------|----------------------|--|------------------|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | 1071.11 | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | |
| | DORIS | MILDRED |) | PA | TTISON | J A N | 23 199 | 7:15 Am | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. | BIRTHPLACE (State or Foreign Country) | | | | | |
| 1 | 222-01-4314 | 1 DM 2 XF 76 | YRS. | | | Apr 4 19 | | Maryland | | | | | |
| ac | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 10cc CVACA Lice the Coanse Coachests | | | | | | | | | | | | |
| 5 | Wesleyan Health Care Center Denton Caroline | | | | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | | | | |
| | - | chester | | Car | mbridge | | | LIMITS? | | | | | |
| PAL | 10e. STREET AND NUMBER | OF WHAT COUNTRY? | | | | | | | | | | | |
| FUNERAL | 413 Robbins | | | 1 | | 613 | | .S.A. | | | | | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2/XNO | If yes, spe | ecify Cuban, Mexica | NIC ORIGIN? (Specify an, Puerto Rican, etc.) | Yes or No — 14 | . RACE — American Indian, Black, White, atc. | | | | | |
| BY | 3 🛣 Widowed 4 □ Divorced | IF YES, GIVE WAR ON DE | ITES | 1 L YES | NO Specif | fy: | | Specify white | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 18a. OECEDENT'S | USUAL OCCUPATION | ON set of working | 16b. KINO OF E | BUSINESS/INDUS | TRY | | | | | |
| Ē | Elementary/Secondary (0-12) | College (t-4 or 5+) | Ille. Do NOT u | ise retired.) | | | | | | | | | |
| M | 8 17. FATHER'S NAME (First, Middle, Last) | | norse u | rainer/ow | | | | | | | | | |
| | Leslie | Sparks | | | 18. MOTHER'S NA | AME (First, Middle, Meid Edith | | illey | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | - Sparin | 19b. MAILIN | D ADDRESS (Street a | and Number or Rural | Route Number, City or 1 | | | | | | | |
| 임 | Hazleton L. Short | ter, Jr. | | | | aston MD | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Remo | 20b. | PLACE AND DATE | OF DISPOSITION (Na | | | LOCATION — City | or Town, State | | | | | |
| | 4 Donation 8 Other (Specify) | Ea | netery, cremetory or o | Market Ce | | | st New 1 | Market Md. | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | | | as Funera | | | | | | | | |
| | > Kennett A | Q. Thomy | 4. | | | t. Cambri | dae MD : | 21613 | | | | | |
| | 23. PART i. Enter the diseases, or c ahock, or heart fellure. I | complications that caused List only one cause on as | I the death. Do | not enter the mo | de of dying, auc | ch aa cardiac or res | apiratory arrest | Approximata Interval Between | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | OTHER PROPERTY. | Onest as | | | | | | | | | | |
| 1 | disease or condition resulting in death) a. Small bound obstruct Due to (or as a consequence of): Previous terminal obstruct Sequentially list conditions. | | | | | | | | | | | | |
| , | | Drewis | ~ Lan | FIE ALOEK | chan Bur corcinal d | | | | | | | | |
| 00 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE O | F): | 1 100 | CO 51.41 0 | | | | | | | |
| S | cause. Enter UNDERLYING | c | | | | | | | | | | | |
| CERTIFICATION | that initiated events | OUE TO (OR AS A | CONSEQUENCE O | F): | | | | | | | | | |
| 병 | | d | | | | | | | | | | | |
| A | PART II. Other significant condition | a contributing to death b | ut not resulting | In the undariying | g cause given in | | AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO | | | | | |
| MEDIC | | | | | | 1 YES | 2 SONO | COMPLETION OF CAUSE OF DEATH? | | | | | |
| ME | | | | | | - 1 | | 1 - YES 2 - NO | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | OTHER: | ACE OF OEATH (Ch | | | | | | | | |
| H | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIM | ME OF 28c. INJ | URY AT | 8 Other (Specify) 28d. DESCRIBE HON | W INJURY OCCUR | ED | | | | | |
| | 1 Netural 5 Pending Investigation | (Month, Day, Year) | JN. | JURY WO | PRK? | | | - | | | | | |
| ED BY | 3 Suicide 8 Could not be | 28a. PLACE OF INJURY building, atc. (Spec | - At home, farm, | street, factory, office | • | 281. LOCATION (Street | | Rural Route Number, | | | | | |
| ETE | 4 Homicide defarmined | | | | | City or Town, Sta | no) | | | | | | |
| 29a. CERTIFIER (Check only PHYSICIAN: To the best of my knowledge, dash occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| BE 0 | 296. SIGNATURE AND VITLE OF CERTIFIER | R | | | 29c. LICENSE NUI | MBER | 29d. DATE SI | GNED (Month, Day, Year) | | | | | |
| 70 | 194 / YOU | my, | | | 0370 | 136 | 1/ | 25786 | | | | | |
| | DR. GARY SPROUS | | | | CHES | TER, MD | 21619 | | | | | | |
| | | | | | | | | | | | | | |
| | 31. DATE FILED (1901), Day, 1901 1996 32/HEGISTRAN'S SIGNATURE PARALLE | | | | | | | | | | | | |



3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH

the hospital or attending physician. MARYLAND 21215-0020 BALTIMORE.

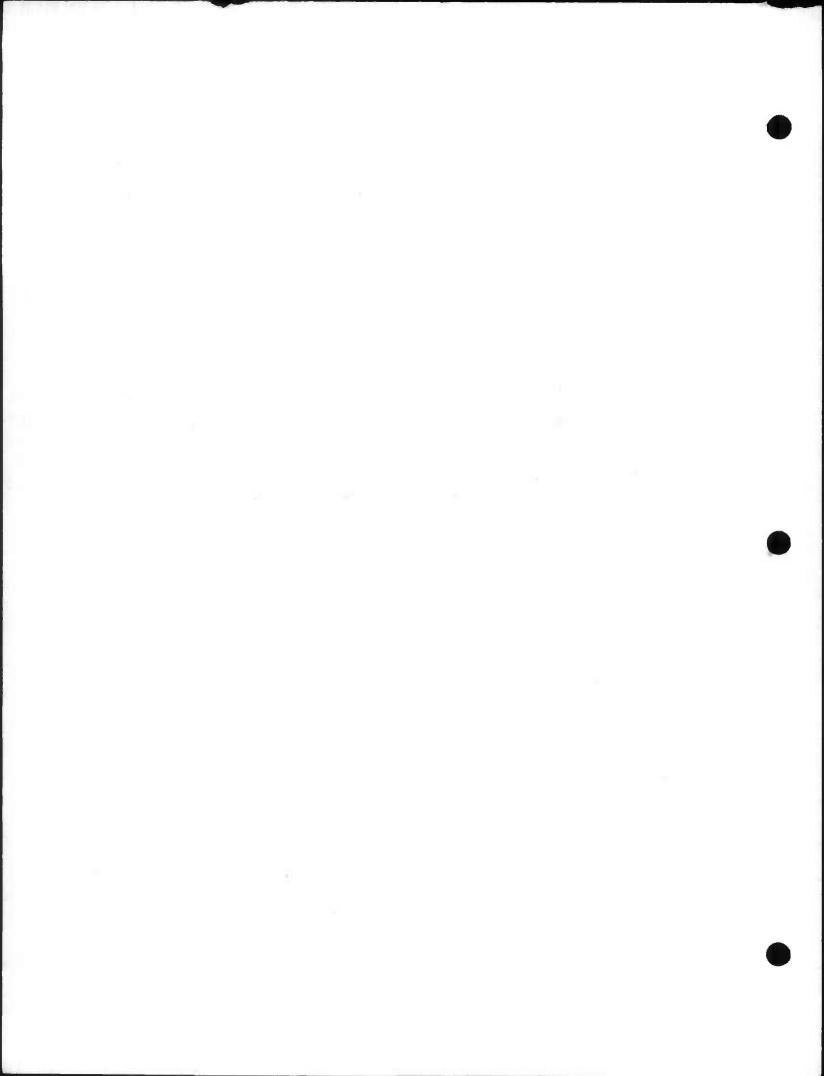
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Last)

68760 DIVISION OF VITAL RECORDS, P.O. BOX

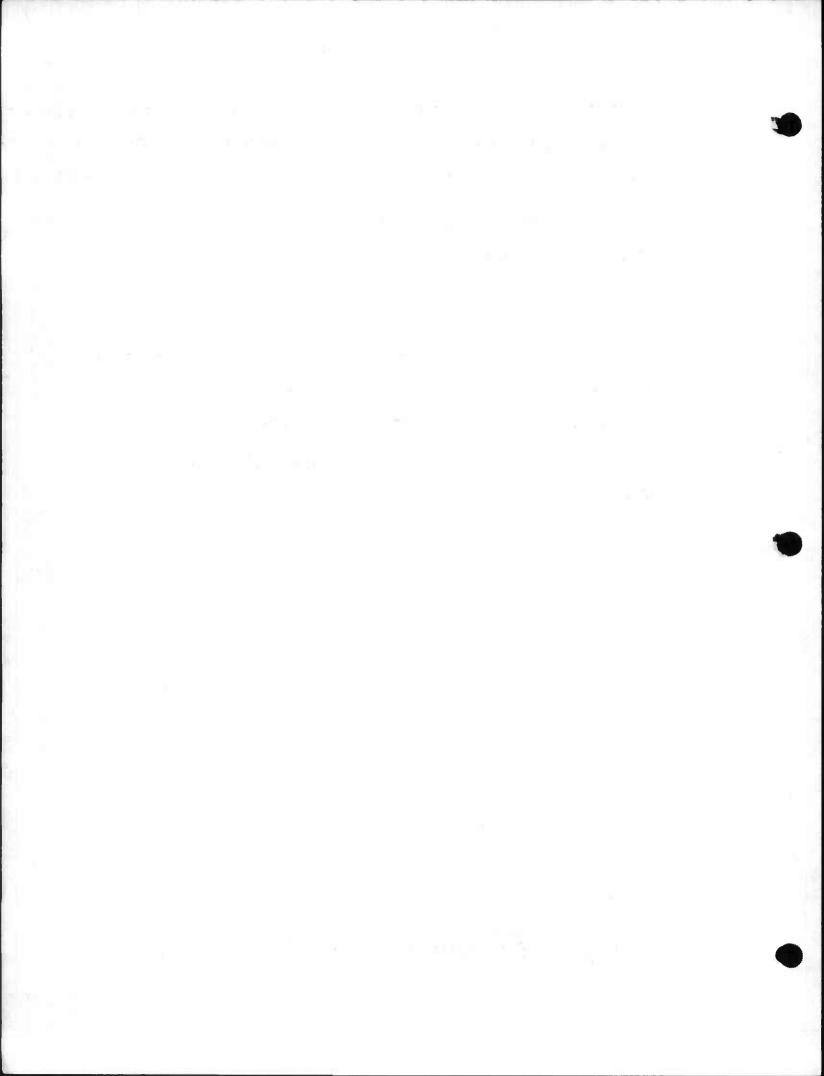
GERALD CHRISTOPHER PHILLIPS-PARKER 1996 PM January 28 7:43 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 6. AGE (In yrs. last birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN 1 M 2 D F 219-94-0326 YRS. November 1 Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 14102 South Springfield Road Brandywine PRINCE GEORGE'S RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George's Brandywine t YES 2 XNO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14102 S. Springfield Road 20613 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 Married It yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2X NO Specify: Spec/fy BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY detached for Elamentary/Secondary (0-12) College (1-4 or 5+) Waterman 12 Sea Food Industry once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 2 76 Richard A. Phillips hours after death. Page 6 may be retained by Barbara K. Wenn Goldsmith BE notified page 5 should 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Barbara K. Goldsmith 14102 S. Springfield Rd Brandywine, MD 20613 pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must funeral director, Other (Specify) Trinity Memorial Gardens Waldorf, MD examiner AL SERVICE LICENSEE 21. SIGNATURE & 22. NAME AND ADDRESS OF FACILITY MOQ173 J.H. Eberwein Mortuary Pexwer 11855 #104 Holly La Waldorf, MD 20601 the medical 21 PAHTA. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and completely filled in by a burial, cremation, or remo shock, or heart fellure. List only one ceuse on each line. Interval Between Onset and Desth IMMEDIATE CAUSE (Finel the disease or condition DUE TO (OR AS A CONSEQUENCE OF): certificate be executed within event, resulting in desth) Talnutrition Mths traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 2 If any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in desth) LAST 0 the death PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS 30 AVAILABLE PRIOR TO OR ATTENDING PHYSICIAN: The law requires that any COMPLETION DF CAUSE signed Health a 1 YES TO NO t, of Heal. 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State I, or Item OTHER:
4 \(\text{Nursing Home} \(5 \text{X} \) Rasidence \(8 \) Other (Specify) HOSPITAL: I YES NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 27. MANNER OF DEATH 28b. TIME OF INJURY 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with t marked, 1 X Natural 5 Pending Investigation 1 YES 2 NO BY After 1 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town State) 8 Could not be determined DIRECTOR. A hours after d item 28 is 60 COMPLETED FUNERAL DIRECT WITHIN 72 HOURS A 29a. CERTIFIER (Chack only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steled. HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE D39501 ▶ January 30, 1996 Im welder My 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hugh Holder MD 13605 Baden Westwood Rd Brandywine, Maryland 20613 31. DATE FILED (MONTO DE 32. REGISTRAR'S SIGNATURE
JULIA D'RUBLION RONSOLL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 96 03807

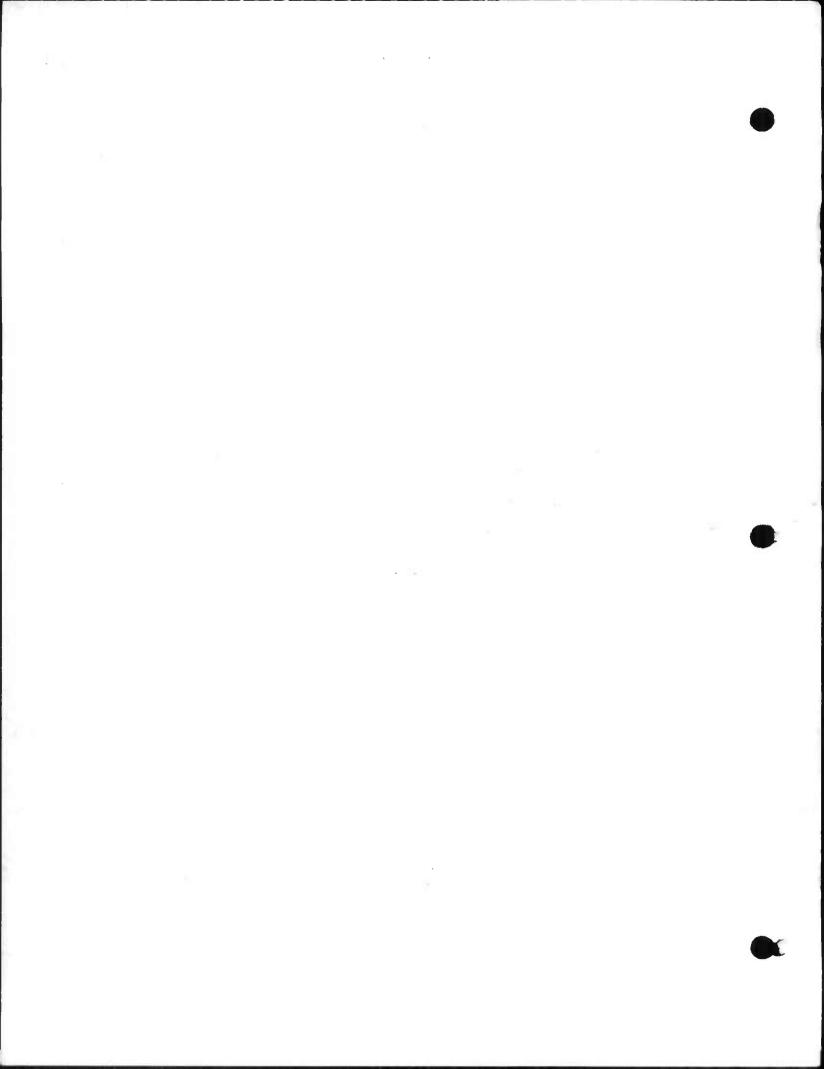
| | | | | | | Certificate | e of | Death | | В | eg. Nc | | | |
|--------------------------------|--|----------------|---|--|---------------------------------|--------------------------------------|----------------|------------------------|------------|---------------------------------|----------------|--------------|-------------------------------------|---------|
| | 2 | | 1. Decedent's Nama (First, Middla, La | st) | | | | | 2 | . Data of Deal | th | | 3. Tima of D | eath |
| | Physici Medi- | | BESSIE I | CORETTA | PIERCE | | | | | Month Jan. | Day 25. 1 | 996 | 12:0 | Opm |
| T | Examir | | 4a. Facility Nama (If not institution, glv | | | | | 4b. City, Town | | | | y of Death | 12.0 | opin |
| | | | 1505 Stonele: | igh Court | | | | Hunti | ngto | own | | Calv | ert | |
| | Funeral | | Social Security Number 6. S | ax 7. Aga ☐ M 2♥ F | (In yrs. last birtl | Months | 1 Yaar Days | If Undar 24 Hours | Min. | . Data of Birth (Month, Day, | Year) | 9. Birthp | lace (Stata or | Foraign |
| Ь | Director | | 5/0-03-43/0 | | 82 Y | rs. | | | A | pr 4, | 1913 | Mar | yland | |
| | and * = | | Usual Rasidance of Decadant 10a. Stata 10b. County | | IOc. City, Town | or Location | | | | | | 1 | 0d. Insida City | Limite |
| | Vanyl faho | 0 | MD | Calvert | | ngtown | | | | | | | 1 Yas 2 | |
| | the 128s | Director | 10e. Street and Number | , da 1 0 1 0 | 1101101 | 10f. Zip | Coda | | | 1 | 0a. Citizan of | What Cour | ntry? | |
| | with with | | 1505 Stonele: | igh Court | | 1011 2219 | 0000 | 206 | 39 | | USA | Wild Cour | , . | |
| | 72 hours after death with the Manyand natural; or items 23s or 28s-f show dical Examiner must be notified at | Funeral | 11. Marital Status | 12. Was Decedant Ev | ar in U,S. | 13. Was Deced | ent of I | | | ly Yas or No- | | ca - Americ | an Indian, | |
| 0 | or the | | 1 Navar Married 2 Married | Armed Forcas? | | | | | Puarto Rio | cen, atc.) | Ble | ick, Whita, | atc. | |
| 02 | mal, c | by | 3 ☑ Widowed 4 ☐ Divorced | If Yas, Giva Yaar or Datas: | | 1 ☐ Yas 2 | XI No | Specify: | | | Speci | whi | te | |
| 5-0 | in 72 hours "netural", edicsi Exe | Completed | 15. Decedent's Ed (Specify only highest gre | | 16a. l | Decedant's Usua 'Giva kind of wor | l Occup | ation during most o | of working | | 16b. Kind of E | Businass/Ind | dustry | |
| 121 | d within giene. r than " | JQ. | Elemantary/Secondary (0-12) | Collega (1-4or 5+) |) | Giva kind of wor lifa. DO NOT us | | d) | | | | | | |
| 2 | 77 70 1 | | 17. Father's Nema (First, Middla, Last, | 1 | h | ousewi | fe | 40.00.00.0 | | | | hom | le | |
| and | S E D | Be | | | | | | | | First, Middla, M | | | | |
| 2 | d 2 should be th and Mental 7 Is marked or traumatic eve | ٦ | John E. Beall 19a. Informent's Name/Ralationship (| Time Reintl | 106 | Maliing Addrass | /C++== | Pea | | Davida Albambaa | | wens | | |
| Ma | d the | | George E. Pier | ** | | ame as | | | | HODIA PUINDE | , City or Town | , State, Zip | Code) | |
| re, | - DEF | | 20a. Mathod of Disposition | | 20b. Place of | Disposition (Nem | a of | | | Data | 20c. Location | - City or To | wn, Stata | |
| OT. | age ent of rt: If if | | 1 M Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | | , crematory or of | | | - 01 | /27 0 | C 0 | 441 | a a ME | |
| Baltimore, Maryland 21215-0020 | permit. Pages 1 Department of H Important: if ite any injury or of once. | | 21. Signature of Funeral Service Licer | 107 | Cedai | Hill 22. Nama and | | | y (U I | 121-9 | 6 Su | ıtıaı | na, ML | , |
| ä | Depa Impo any I | | 1/1/Den 24 | | | 3030000 | | es ares | 7 77. | La . | | 0 : | | |
| | _ | | 23a. Part1. Entar tha disaa | plicetions that ceused th | na daath. Do no | Rausc | | | | | | Owin | Approximata | D |
| | Physician | ő. | 23a. Part1. Entar tha disaa dor dom shock, or haart failura. Unit only | ona causa on aach lina. | | | | | | adpiratory arri | | 1 | Intarval Batwe Onsat and De | |
| Ţ | /Medicai | | Immediata Causa (Final | 0. | 1.1 | deno | | - | | | | - | 100 0 5 | |
| ľ | Examiner | | disaasa or condition rasulting in daath) | a. / Cee | ua to (or as a co | | N | reinn | na | | | 1 | mos. | |
| | | Je | | 5 | Da to (or as a ci | misequance or). | | | | | | 1 | | |
| | certificate be executed rding physician and use es the burial-transit | Examiner | Sequentially list conditions, | b. Du | ua to (or as a co | onsequance of): | | | | | | | | |
| 0, | e exe | | Sequentially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Cause (Disaase or Injury | | | | | | | | | į | | |
| 68760, | hysic the b | Medical | thet initiated avents rasulting in death) Last | Du Du | a to (or as a co | nsequance of): | | | | | | | | |
| 9 x | | | L | d | | | | | | | | i | | |
| Box | ires that the death ce signed by the attendid d be detached for use | Physician/ | | | | | | | | | | | | |
| o | the de | ysl | Part II. Other significant conditions of | ontributing to death but | not rasulting In | tha undarlying ca | usa gi | an in Part I. | | | | | the cause of | |
| Δ. | that the ded by deta | | | | | | | | | 1 🗆 Y | es 2 No | 3 Prol | bebly 4 🗆 U | nknown |
| ds, | requires seen sign hould be | d by | | | | | | | | 24a. Was a | n autonsv | 24b. W | are autopsy fin | dinas |
| 00 | _ 0 0 | lete | | | | | | | | perforr | | ava | ailabla prior to mpiation of car | |
| Re | The law ate has b page 2 s | Completed | | | | | | | | | | | death? | |
| ā | iclan: The certificate rector, pag | | 25. Was cesa rafarred to medical | | | | | | | L | as 2 No | 11 | Yas 2) SN | 10 |
| of Vital Record | | To Be | axaminar? 1 ☐ Yes 2 ☑ No | Hospital: | 2 ER/Outs | patient 3 DO | , Oth | or | | Check only on 5 Raside | | has (Canail | nel . | |
| | Phys er this eral di | | 27. Mannar of Death | 28a. Data of Injury (Month, Day) | | ma of 28 | Bc. Inju | | | d. Dascribe ho | | | Y) | |
| 0 | Attending or death. Sctor: After by the fune | atio | 1 Natural 5 Panding 2 Accident invastigation | | rear) in | ury M | | Yas 2∐ No | 0 | | | | | |
| Division | or Attending after death. Director: After In by the fune | Certification: | 3 Suicida 6 Could not be detarmined | 28e. Piace of Injury building, etc. | | n, straat, factory, | , office | | 281 | Location (St City or Town | | ber or Rure | Routa Numbe | er, |
| | tal or A | Cer | | bullding, etc. (| Specify | | | | | ony or row | , olulo) | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edicai | 29a. Cartifiar 1 Certifying Ph | ysician: To the best of a | ny knowledge, kamination and | deeth occurred a | t tha th | ma, data and | place, end | dua to the co | euse(s) end m | anner as si | tated. | |
| | the the | Med | Uney | and mannar state | d. | | | | | | | | | |
| | 5 × 5 0 | - | 29b. Signature and title of certifies | 1.00 | 11 | | | e number | | | 9d. Date sign | | Day, Year) | |
| | (0 | ļ | Hover y | Acutas | m C | | 116 | 823 | | | 1-26- | 16 | | _ |
| | Ψ | | 30. Nama and eddress of person who | complated ceuse of d | th (Itam 23e) (T | ype, Print) | | | | | | | | |
| | Cha | 10 | 31. Data filed (Month, Day, Year) | 32. Registrar's | s Signatura | | | | <u> </u> | | | | | |
| | Sta Registr | | JAN 3 0 1 | | My Jest-A | ardall | | | | | | | | |
| | | | 0 | , | | | | | | | | | | |



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an order of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

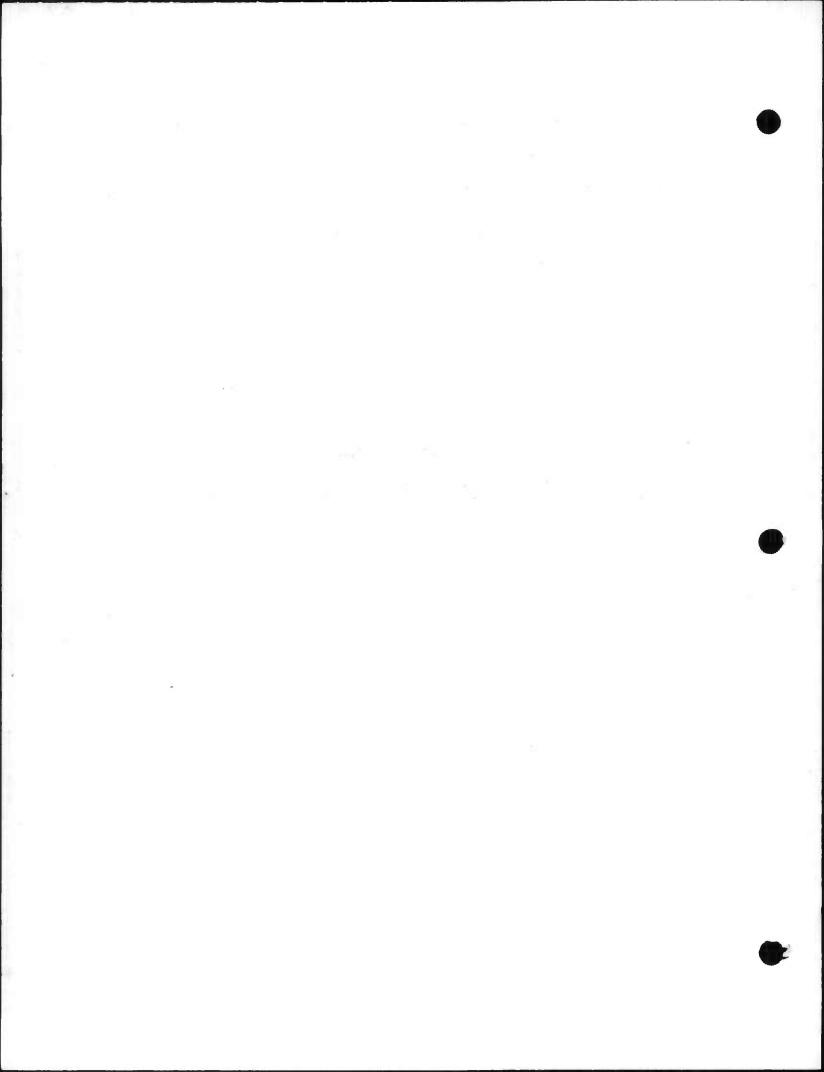
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | | | MENTAL HYGIE | | | | |
|---------------|--|---|----------------------------------|--------------------------------|--------------------------------------|--|---------------------------|-------------|---|---|
| Ĭ | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. | TIME OF DEATH | |
| | LOUETTA ANNA | 4 P | ARSONS | | | JANUARY | 24 19 ⁹ | 96 | 1:28P | М |
| | 216-01-3919 | 1 🗆 M 2 💢 F | yrs. lest birthday) _ 93 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 02 | Coupty) | | |
| TOR | BERLIN NURSING & | | TR. | BERI | _ I N | EATH | 9c. COUNTY WOR | CES | | |
| DIRECTOR | MD. WICON | 4100 | | TSVILI | | | | - | d. INSIDE CITY LIMITS? YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER | | | | H. ZIP COOE | | | | T COUNTRY? | |
| NE | MELSONS ROAD | IN HIS DECEDENT CHES IN | | | 21850 | | | SA | | |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN L FORCES? 1 TYES IF YES, GIVE WAR OR OAT | 2 NO | If yes, a | pecity Cuben, Mexico S 2 NO Speci | NIC ORIGIN? (Specify en, Puerto Ricen, etc.) ly: | Yas or No- 14 | Black, W | American Indian, hita, atc. WHITE | |
| COMPLETED | 15. DECEOENT'S EDUCAT (Specify only highest grade col Elementary/Secondery (0-12) | TION Impleted) College (1-4 or 5 +) | Give kind of we life. Do NOT use | ork done during m retired.) | ION ost of working | 166. KIND OF E | HOME | TRY | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | AME (First, Middle, Maid | en Sumame) | _ | | _ |
| BE C | GEORGE L STE | ERLING | | | | IA MOORE | | | | |
| TO B | BETTY P. BUNTIN | N G | 19b. MAILING | CAREY | RD. | B. ERLIN, | D., State, Zip Co | 218 | 11 | |
| | 20e. METHOD OF DISPOSITION 10 Burlel 2 Cremetion 3 Remova | of from State cemet | EACE AND DATE OF | er placa) | eme of | 0ATE 20c. | LOCATION — CITY PITTSV | | | |
| | 21. SIGNATURE OF PURENA/SERVICE UCEN | 1 | | 22. NAME / | NO AODRESS OF FA | UNERAL H | | | LIN, MD | |
| | 23. PART I. Enter the diseases, or con shock, or heart failure. Lis | Ri only one cause on eac | th line | | | | | | Approximate Interval Between | |
| | IMMEDIATE CAUSE (Final disease or condition reaulting in death) | arterio | seler | otie | Hear | elenor | rease | _ | Onset and Dea | |
| _ | | Cenera | line of | 2 (2) | LIADE | Rose |). | | 6 41 | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A C | ONSEQUENCE OF | 0-0 | | | | | 7 | _ |
| FIC | CAUSE (Disease or Injury that Initiated events | DUE TO (OR AS A C | ONSEQUENCE OF | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | |
| | PART II. Other algnificant conditions of | contributing to death but | not reaulting in | the underiving | o cause given in | Part i. 24a WAS | AN AUTOPSY | 245 WE | RE AUTOPSY FINDING | |
| ICAL | arterioselerale | e Cardior | ascula | · De | rease. | PERF | ORMED? | CO | MILABLE PRIOR TO MPLETION OF CAUSE | 3 |
| MEDIC | Vestie Weer. | . Histal | Hernis | ٤. | | 1 TYES | 2 XNO | | DEATH? YES 2 XNO | |
| ä | DID TOBACCO USE CONTRIB | BUTE TO CAUSE OF | DEATH YES | □ NO [| UNCERTAI | N 🗆 | | | - 20 | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26 IOSPITAL: | . PLACE OF DEATH | (Check only one | | | | | | |
| 1YS | 1 YES 2 NO 1 | 28e. DATE OF INJURY | | Nursing Ho | | 6 Other (Specify) | | | | |
| BY P | 1 X Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJŪ | RY W | JURY AT DRK? YES 2 NO | 26d, DESCRIBE HOV | INJURY OCCUR | ED | | |
| COMPLETED B | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, stc. (Specify, | At home, lerm, st | reet, factory, offic | e e | 281. LOCATION (Stree City or Town, Ste | | Rural Route | Number, | |
| PE | 29e. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAL | N: To the best of my knowled | ige, death occurred | st the time, dat | and place, and due | to the cause(a) and π | snner sa stated, | | | |
| NO. | | On the basis of examination e | | | | | | euse(s) an | d manner as stated. | |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | · (D) | 2 | 20 | 29c. LICENSE NUI | MBER | | | onth, Day, Year) | ╗ |
| 6 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CALLS OF DEAT | H STEM OT ST | mo | D29505 | 5 | 1 / - | | | |
| 1 | GREGORIO BELLOSO, | MD 4421 | BEECHWO | OOD PLA | CE CRIS | FIELD,MD 2 | 21817 | 410 968- |)– -3149 | |
| ′ | JAN 25 1996 | JE STATE OF SIGNAT | AAA. | | | | | | | |



FOR STATE

| | _ | - | REGISTRAR | | | CERTIF | ICATE (| OF DEATH | | REG. NO | | | | |
|--|---|-------|--|-------------------------------|------------|---------------------------------|------------------------|--|----------------|-------------------|-----------------------------|----------------|--|----------|
| | | | 1. DECEDENT'S NAME (First, Middle, Las | | | | | | 2. DAT | TE OF DEATH | · | 3. | TIME OF DEATH | |
| | - 1 | | Edwin | Essmund | Pier | cce. Sr. | | | Jar | | $\overset{\text{AY}}{2}1$ 1 | 1996 | 1355 | 8.6 |
| | | ı | 4. SOCIAL SECURITY NUMBER | 5. SEX | _ | In yrs. last birthday) | IF UNDER 1 YE | AR IF UNDER 24 HRS. | | E OF BIRTH | 21 1 | | | - |
| | | | 214-36-9383 | 1 1 M 2 F | | | | YS HOURS MIN. | (Mo | nth, Day, Year) | | Country) | ACE (State or Foreign | |
| 9 | | - | | 1 | | 6 YRS. | | | | 12, 1 | 939 | Ma | ryland | |
| 3 should | ۱ " | . 81 | Se. FACILITY NAME (If not institution, give | | | | 9b. CITY, TO | WN DR LOCATION OF | DEATH | | 9c. COU | NTY OF DEAT | ЛН | |
| 2, 3 | اة ا | | Harford Memori | al Hospit | al | | Ha | avre de Gi | race | | | На | rford | |
| ₩. | 5 | | RESIDENCE OF DECEDENT 10e. STATE 10b. COUN | | | | | | | | | | | |
| 90 | DIRECTOR | | | | | 10c. CI1 | Y, TOWN OR L | | | | | 10 | Id. INSIDE CITY LIMITS? | |
| permit. Pages 1, | | - 16- | Maryland | Cecil | | | Po | ort Deposi | it | | | 1 | YES 2 NO | |
| per | | | 10s. STREET AND NUMBER | | | | | 101. ZIP CODE | | | 10g. CITI | ZEN OF WHA | T COUNTRY? | |
| 020 physician. burial-transit | FUNERAL | | 250 North Main | Street | | | | 2 | 21904 | | | U.S.A | | |
| al-tre | 3 | | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER # | U.S. ARMED | 13. WAS | DECENDENT OF HISP | ANIC ORIG | IN? (Specify Yes | or No — | 14. RACE — | American Indian, | |
| Paris Paris | | | 1 Never Married 2 Married | FORCES? 1 IF YES, GIVE W | | | If ye | s, specify Cuban, Mexi YES XX NO Spec | can, Puert | o Rican, etc.) | | Black, W | /hila, etc. | |
| 15-0 ending as the | ₩ | 12 | 3XXWIdowed 4 Divorced | 11 120, 0112, 11 | An on Di | 1123 | '' | AES ALVINO She | спу: | | - 1 | Specify: | White | |
| 215-0020 attending physic se as the burial | 유 | | 15. DECEDENT'S EC | UCATION | | 16a. DECEDENT'S | USUAL OCCU | PATION | 10 | Bb. KIND OF BU | SINESS/INC | MISTRY | | _ |
| 2121 al or arth for use | 15 | ŀ | (Specify only highest gra- Elementary/Secondary (0-12) | | | (Give kind of life. Do NOT u | work done durin | g most of working | | berdee | | | Ground | |
| of to | 교 | | Nine Years | College (1-4 or 5 + | ' | Fire | man | | | berdee | | | | |
| AND 21 the hospital or detached for | once. | | 17. FATHER'S NAME (First, Middle, Last) | | | 1110 | man | | | | | Lylan | 7 | |
| 7 4 5 | | | | . Pierce | | | | | | , Middle, Maiden | | 4.1 D. | 1 | |
| E S B | | - | 19a, INFORMANT'S NAME (Type/Print) | . rierce | _ | | | | | ces El: | | | are | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-tran | TO BE | | Bonnie S. Perkin | _ | | | | eet end Number or Rure | | | | | | |
| De 5 | - Pe | - 11- | | | | 250 No | rth Ma | in Street | , Po | rt Depo | sit, | Mary! | land 2190 | 4 |
| R May | 75 | | 20a, METHOD OF DISPOSITION 1.A. Burial 2 Cremation 3 Re | movel from State | 20b. | PLACE AND DATE | OF DISPOSITIO | N (Name of | DA | TE 20c. LO | CATION — | City or Town, | State | |
| O e e | Hust | | 4 Donation 5 Other (Specify) | | . Cem | Hopewell | $\Gamma^{prece)}$ Ceme | tery | 1/24 | /96 Por | t De | posit. | , Marylan | d |
| BALTIMORE, after death. Page 6 may be by the funeral director, page | examiner | | 21. SIGNATURE OF FUNERAL SERVICE I | ICENSEE | | | | E AND ADDRESS OF | FACILITY | | | | | Ť |
| The earth | E | | * Thomas | M Fall | CLA | TO . | Le | e A. Patt | erso | n & Sor | Fun | eral H | lome | |
| 四声音 | - | -, | Similar | H. CELL | CIC | 10119 | P∈ | rryville, | Mar | yland | 2190 | 3 | | |
| BALTIMORE, hours after death. Page 6 may be od in by the funeral director, page or removal. | medical | Ш | 23. PART I. Enter the diseases, or ahock, or heart failure | Complications that | caused | the death. Do i | not enter the | mode of dying, su | ich aa ca | rdiac or respi | ratory arr | reat, | Approximata | |
| 3760 rted within 24 hours completely filled in rial, cremation, or re | | | IMMEDIATE CAUSE (Final | . Liet Dilly Dile Cad | od Dil de | acti iiie. | | | | | | | Onset and Deat | |
| ation at | Ě | | disease or condition | CERE | BRI | OVASCL | MAR | Acci? | \E 11 | T | | | 16 DAY | |
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| 6 eeec to but to but | r other traumatic | | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A | CONSEQUENCE O | F): | | | | | | - | - |
| DS, P.O. BOX he death certificate be e the attending physician: Mental Hydiene prior to | Y Is | | cause. Enter UNDERLYING | | | | | | | | | | ĺ | - 1 |
| .O. BC certificate ding physic tygiene pri | 희교 | | CAUSE (Disease or injury that initiated events | DUE TO | OR AS A | CONSEQUENCE O | F): | | | | | | | - |
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| | 울 | | PART II. Other aignificant condition | | | | in the under | ying cause given i | n Part i. | 24a, WAS AN | | | RE AUTOPSY FINDINGS | s |
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| F VITAL SICIAN: The Jay certificate has the State Dep | Item SICL | | EXAMINER? | HOSPITAL: | | 26. PLACE OF DEA | OTHER: | one) | | | | | | |
| ZIAN Triffic | YS | | 1 TES 2 X NO | HOSPITAL: 1412 Inpatient 2 | ER/Outp | atient 3 DOA | | Home 5 🗆 Residence | 6 🗆 Ott | er (Specify) | | | | |
| OF VITA PHYSICIAN: The this certificate h with the State | ed, or item 23 PHYSICIAN | | 7. MANNER OF DEATH | 28a. DATE DF (Month, De | | 26b. TIM | E OF 28c | INJURY AT WORK? | 28d. DI | ESCRIBE HOW I | NJURY OCC | CURED | | П |
| Zose | 른 . | - 10 | 1 Natural 5 Pending 2 Accident Investigation | | ,, | 1 | | YES 2 ND | | | | | | - 1 |
| ON ODING | 10 | | 3 Suicide 6 Could not be | 26a. PLACE OF | INJURY | — Al home, farm, | treet, lactory, | office | 281. LO | CATION (Street a | nd Number | or Rural Route | Number, | \dashv |
| DIVISION OR ATTENDING F DIRECTOR: After hours after death | 90 111 | | 4 Homicide detarmined | bullding, o | acc. (apac | πγ) | | | CI | y or Town, State) | | | | н |
| DIV OR A DIREC | ANT: If Item 2 COMPLET | | 9a. CERTIFIER VIV | | | | | | | | | | | 4 |
| | = P | 1 | Check only | SICIAN: To the best of | my knowl | edge, death occurr | d at the time, | data and place, and du | e to the c | euse(s) and man | ner aa stati | ed. | | - 1 |
| THE HOSPITAL THE FUNERAL filed within 72 is | \$ 0 | L | 2 MEDICAL EXAMIN | EST. On the beets of an | emination | and/or investigatio | n. In my opinio | et, death occured at th | ne time, det | te and place, and | d due to the | e ceuse(s) an | d manner as stated. | - 1 |
| THE HE | PORT BE | | 96. SIGNATURE AND TITLE OF CERTIFI | n of day | 1/ 1 | Mari | | 29s, LICENSE NO | меся | | 29d. DATE | E SIGNED (Mo | orith, Day, Year) | 7 |
| 5 6 5 % 5 4 5 % | | | | X Mill | na | whende | 60 | D453 | 44 | | D /- | -23- | 9/2 | |
| | 를 입 | 1 | O. NAME AND ADDRESS OF PERSON W | | | | | | | | | | | \dashv |
| | | | Suresh M. Dhanja | | | | | d. Port D | enosi | t. Mar | vland | 1 2100 | 4 | |
| | | 3 | 1. DATE FILED (Month, Day, Year) | 32. REGISTRAI | T'S SIGN | TURE | | _, D | - POD1 | -, mar | Lanc | 2170 | 7 | 4 |
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 03810

| Judge Ralph W. Powers, Sr. Cinger Cove Health Care Center S. Social Social Social Social Professional Communication of Control Professional Control Professional Control Professional Communication of Control Professional C | | 1. Decedent's Neme (First, Midd | le, Last) | | | | | 2. Dete of De | Reg. No. | | 3. Time of Death |
|--|---------------------|--|------------------------------|----------------------|-------------------------------|---------------------------------------|--|---|-----------------------------------|---------------------|-----------------------|
| Singer Cove Health Care Center 7. Ang it yrs. set bidding logs. 8. Set Singer | iysician Medical | | | | | | . Al. T | Januar | y 21 199 | 96 | 2:40P |
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| 100 | neral ector | 5. Social Security Number | 6. Sex 7. | Age (In yrs. lest bi | Me | | | (Month, De | th by, Year) | 9. Birthpl Count | ece (State or Fore |
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| 20b. Method of Disposition Delegation | 1 | | ship (Type, Print) | 198 | b. Maliing A | ddress (Street | end Number or Ri | ural Route Numb | er, City or Town | Stete, Zip | Code) |
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| 23a. Part I. Enter the disease, or certifications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, inferiors between concerning the cause of each line. 23a. Part I. Enter the disease, or certifications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, inferiors between concerning the cause of each line. 25a. Due to (or es a consequence of): 25a. Due to (or es a consequence of): 25b. Due to (or es a consequence of): 25c. Due to (or es a consequence of): 25c. Due to (or es a consequence of): 25c. Due to (or es a consequence of): 25c. Were supply lines of probably and the cause of death of the cause of | 5 | | | 20b. Plece o | of Dispositio | n (Neme of | | | | | wn, Stete |
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| shock, or heart fellure. List only one cause on each line. Immediate Cause (Finel decision or coulting in death) Due to (or ea a consequence of): | | DIAMA | WS | | - | | | | | ,110, | |
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| 25. Wes case referred to medical examiner? 1 | JE O | | | | | | | 10 | Ves YM No | | |
| 27. Menner of Death Nature S Pending Investigation Suicide A Cartifying Physician: To the basis of examinetion end/or investigation, and ender each of the cause (s) and manner as stated. 29e. Certifier (Check only one) Certifying Physician: To the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause (s) and manner as stated. 29b. Signeture end title of certifier D38158 January 23, 1996 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Lisa A. DiMarzio, M.D. 2003 Medical Pkwy, Suite 100 Annapolis, MD 21401(410~573~) | Ü | 25. Was case referred to medical | ı I | | | | of Diagram | | | | 1 193 ZUNO |
| 27. Menner of Death Naturel S Pending investigation | B | examiner? | Hospital: | atlant of English | uta atlant | Oth | or | | | 0 10 - 11 | 4 |
| 2 Accident 3 Suicide 4 Homicide See. Plece of Injury - At home, ferm, street, fectory, office 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated. (Check only one) Certifier (Chec | | | | | | DOA | 4 X X Yursing F | | | | " |
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| D38158 January 23, 1996 30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Lisa A. DiMarzio, M.D. 2003 Medical Pkwy, Suite 100 Annapolis, MD 21401(410-573- | edical | (Check only 2 Medical | Examiner: On the basis | of examinetion er | e, deeth occ nd/or investi | curred et the tim getion, in my of | ne, dete end plece pinion, deeth occu | e, end due to the urred et the time, | cause(s) and m dete end plece, | anner as sta | ated. the ceuse(s) |
| 30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Lisa A. DiMarzio, M.D. 2003 Medical Pkwy, Suite 100 Annapolis, MD 21401(410-573- | × | 29b. Signeture end title of certifie | | | | 29c. License | e number | | 29d. Date signe | d (Month, L | Dey, Year) |
| Lisa A. DiMarzio, M.D. 2003 Medical Pkwy, Suite 100 Annapolis, MD 21401(410-573- | | P 10 | SUN | 5 | | D381 | 58 | | January | 23, | 1996 |
| Lisa A. DiMarzio, M.D. 2003 Medical Pkwy, Suite 100 Annapolis, MD 21401(410-573- | | 30. Neme and eddress of person | who completed ceuse o | f deeth (Item 23a) | (Type, Print | 1) | | | | | |
| | | Lisa A. DiMarz | io. M.D. 20 | 03 Medic | al Pk | wv. Sui | te 100 A | Annapoli | s, MD 2 | 1401(4 | 410-573-1 |
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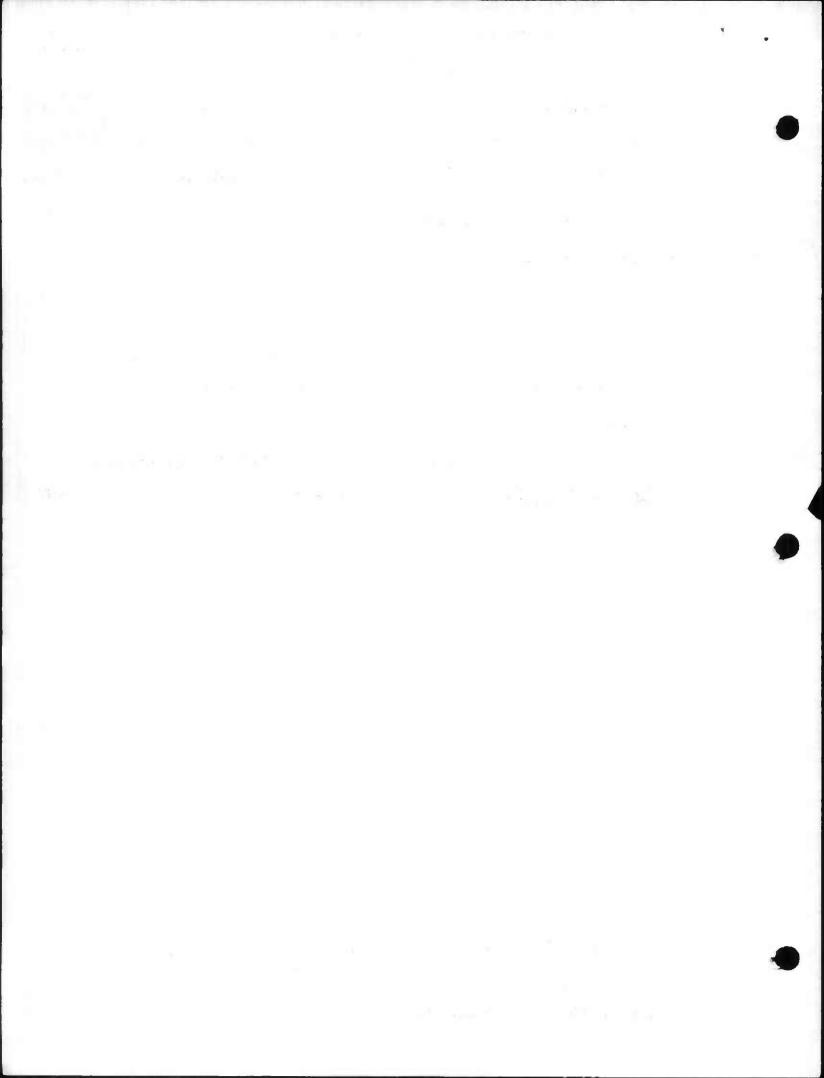
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.

Baltimore, Maryland 21215-0020

Phys /Me Exa

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after deeth. Division of Vital Records, P.O. Box 68760,

| | 1. Decedent'a Nan | ne (First, Midd | lle, Last) | | | | | | | | 2. Dete of D | Reg. | | | 3. Time of Death |
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| 0 | Werner A | | | | | | | | не | тga н | C. Rhir | iena | ITT | | |
| | 19a. Informant's N | leme/Reletions | ship (Typ | e, Print) | | 19b. Me | iling Addre | ess (Stre | et and Num | ber or Run | al Route Num | ber, Cit | ty or Town | , State, Zip | Code) |
| | Donor In | fo. | | | | | | | | | | | | | |
| | 20e. Method of Dis | | | | | Piace of Dis | position (A | vame of | lece) | | Dete | 20c. | Location | - City or To | wn, State |
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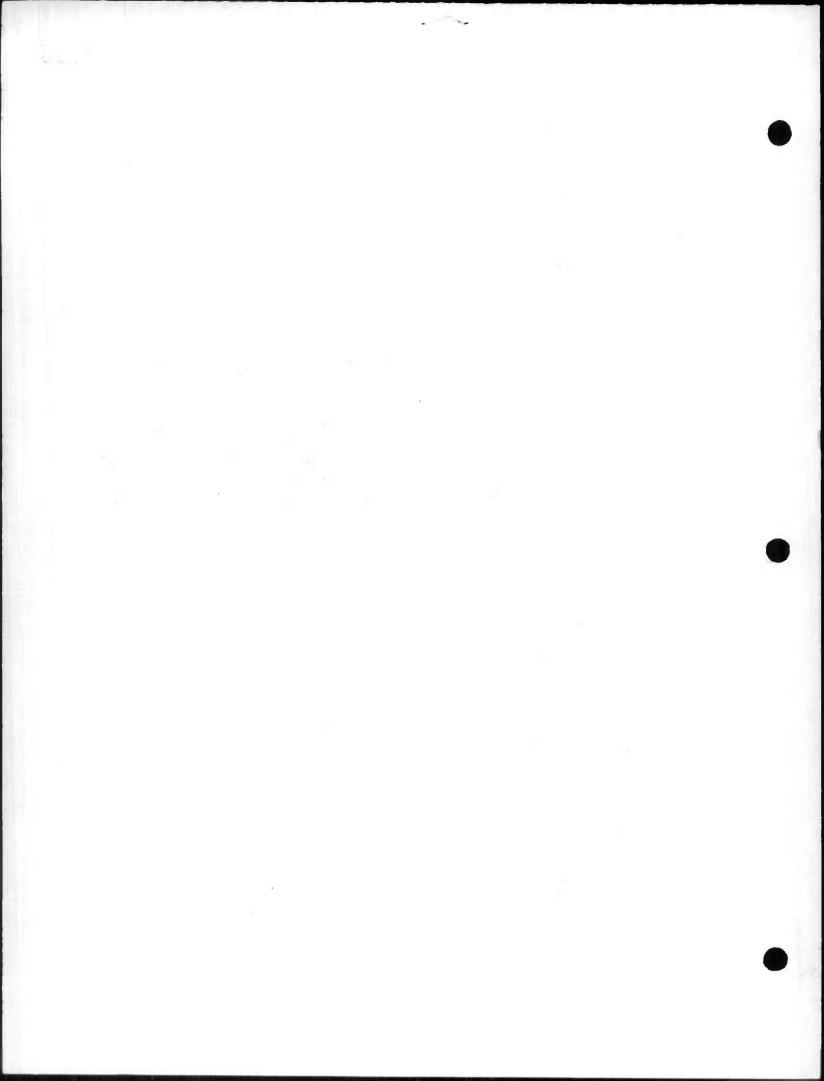
The law requires that the death certificate be

ATTENDING PHYSICIAN:

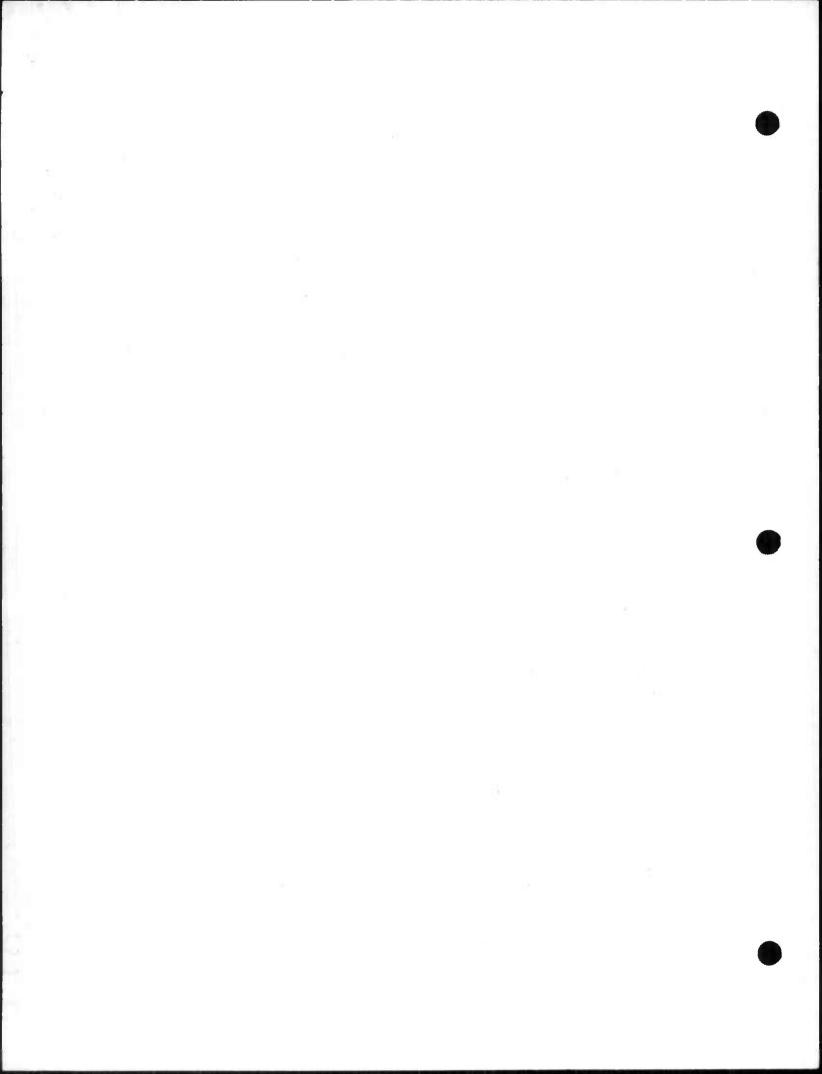
OR

1 -STATE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) PENN 2. DATE OF DEATH 3. TIME OF DEATH San -VCI 996 EMME 7. DATE OF BIRTH (Month, Day, Year) Feb. 28 1920 North Carolina 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 226-16-4431 75 1 M 2 XF Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Howard County General Hospital Columbia DIRECTOR Howard RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 18b. COUNTY 10d. INSIDE CITY Maryland Howard Ellicott City 1 YES 2 X NO permit 10e. STREET AND NUMBER INT. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 4100 College Avenue 21041 U.S.A. burial-transit 13. WIS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES NO 14. RACE — American Indian, Black, White, atc. 1 X Never Married 2 Married Specify: White IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced the use as COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) unknown Por College (1-4 or 5+) Dietary Aid - Cook Food Service detached 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) unknown W unknown page 5 should be notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Sol Fisher 4100 College Avenue, Ellicott City, Md. 21041 90 20b. PLACE AND DATE OF DISPOSITION (Name of 20s. METHOD OF DISPOSITION
1 Burial 2 A Cremation 3 Removal from State 20c. LOCATION - City or Town, State OATE must Balto Washington Crematory 1/26 funeral director, Laurel, Maryland 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY
HARRY H. WITZKE FUNERAL HOME 4112 Old Columbia Pike, Ellicott City, MD. 21043 completely filled in by the or removal. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset end Death IMMEDIATE CAUSE (Finel cremation, the disease or condition resulting in death) 12 days Obstructive event. DUE TO (OR AS A CONSEQUENCE OF): and com Metatata
DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate ceuse. Enter UNDERLYING attending physician mtal Hygiene prior to CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 the atten injury. PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? signed by the any 1 TYES 2 NO shows ; 1 TYES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🕱 UNCERTAIN 🗆 PHYSICIAN: has be Dept. 23 26. PLACE OF OEATH (Check only o 25. WAS CASE REFERRED TO MEDICAL Hem EXAMINER? the State SPITAL: Inpetient 2 - ER/Outpetient 3 - DOA OTHER:
4 | Nursing Home | 5 | Residence | 6 | Other (Specify) 10 28b. TIME OF 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 2 Accident 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 3 Suicide 8 Could not be COMPLETED 4 Homicide detarmined 28 Item CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho IMPORTANT: If IN 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 34613 22 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven 9501 Geller old Annapolis 32. BEGISTRAR'S SIGNATURE
Julia Okurusar Randall 31. DATE FILEO (Month, Day, Year) JAN 2 3 1996 DHMH-16 Rev 1/89



| | | REGISTRAR | | CERTIF | ICATE OF | DEATH | RE | G. NO. | |
|---|--------------|--|---|-------------------------|-----------------------|---|---------------------------------|------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | Pall | | | 2. DATE OF DE | | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | S. SEX BAGE | (In yrs, last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 1 0475 05 04 | 30 9 | P 8:954 " |
| pir | | 237-05-6886 | 1 D M 2 X F 7 | VRS | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIF (Month, Day, | Year) //7 | BIRTHPLACE (State or Foreign Country) V C |
| 1, 2, 3 should | стов | 94. FACILITY NAME (If not institution, give st Williams port RESIDENCE OF DECEDENT | . 1 | Home | 1 /111 . | OR LOCATION OF E | 1 | 9c. COUNTY Was | shington |
| Pages | DIREC | MD. Was | hington | | y, town or Loca | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| permit. | 1 | 10e. STREET AND NUMBER | IIIIgcon | 1 61 | | I TITY, | | 10g. CITIZE | N OF WHAT COUNTRY? |
| 15 | FUNERAL | 12823 Spickle | r Road | | | 21722 | | U.S | .A. |
| 215-0020 attending physician. se as the burial-transit | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, OIVE WAR OR D | 2 NO | If yes, sp | CENDENT OF HISPA Decity Cuben, Mexic 3 277 NO Speci | an, Puerto Rican, e | | RACE — American Indian, Black, White, etc. Specify: White |
| r attending use as the | TED | 15. DECEDENT'S EDUC (Specify only highest grade | | (Give kind of v | USUAL OCCUPATION | ON ost of working | 16b. KIND | OF BUSINESS/INDUS | |
| N E S | PLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Iffe. Do NOT us | se retired.) | | Fai | rchild : | Ind |
| 4 2 E E | COMPL | 17. FATHER'S NAME (First, Middle, Lest) | | LASSEMD | ly Wor | | AME (First, Middle, | | Ziid. |
| # E | BE C | Judson Ellswor | th Petty | | | | e Bell | , | |
| retained by 5 should be notified at | 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | and Number or Rural | Route Number, City | or Town, State, Zip Co | |
| 60 40 | | James Pryor 20a. METHOD OF DISPOSITION | Lan | D. PLACE AND DATE | | | | | ,MD.21722 |
|) w 8 z | | 1 Donation 6 Other (Specify) | oval from Stata Con | netery, crematory or of | ther place) | | 1 | 10c. LOCATION City | |
| AL I IM death. Page funeral direct | | 21. SIONATURE OF FUNERAL SERVICE LIC | INSEE | edar La | 22. NAME A | ND ADDRESS OF F | ACILITY | Hagers | town, MD |
| . 97 | | >///Loga/// | Osla- | | Tho | mpson F | uneral | HOme, I | nc. |
| hours aft or remo | | IMMEDIATE CAUSE (Final | List only one cause on e | each line. | not enter the mo | ede of dying, suc | ch as cardiac or | respiratory arrest | Approximate interval Between Onset and Death |
| ted within 24 completely fill ial, cremation, event, the | | disease or condition resulting in death) | NEUM | ONIA | | | | | 4 DAYS |
| B 2 2 8 | z | | DOE TO (OR AS A | CONSEQUENCE OF | -}: | | | | |
| OA 08 be execut sician and o rior to buri traumatic | ERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | ፣): | | | | |
| phys phys | FIC | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO (OR AS / | CONSEQUENCE OF | n: | | | | |
| T E ST O | HTI | resulting in death) LAST | ı | | | | | | ļ |
| E Me C | 0 | PART II. Other significant conditions | contributing to death b | out not resulting i | n the underlyin | g ceuse given in | Part I 24a V | AS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| T = 55 - | EDICAL | | PHYSEMA | • | | g court given in | P | ERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ₹ Feg Fir | MED | CACHEXIA | | | | | _ ' _ | YES 2 2 NO | OF DEATH? |
| Ser se | | DID TOBACCO USE CONTR | | | | UNCERTAI | N 🗆 | | |
| f aa E | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEAT | OTHER: | | | | |
| the the | PHYS | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 ER/Outp | petient 3 DOA 28b. TIME | | IURY AT | | how injury occur | DED |
| | ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJ | URY WO | YES 2 NO | | | |
| N A P S | 8 | 3 Suicide 6 Could not be | 28s. PLACE OF INJURY building, stc. (Spec | — At home, farm, s | treet, factory, offic | • | 281, LOCATION (City or Town | Street and Number or a | Rural Route Number, |
| OR ATTE DIRECTO hours afte | 1 | an continue | | | | | | | |
| E BE | COMPL | (Check only 1 DC CERTIFYING PHYSIC | CIAN: To the best of my know R: On the basis of exemination | | | | | | ause(s) and manner as stated, |
| THE HOSPI THE FUNER Filed within | шШ | 29b. SIGNATURE AND TITLE OF CERTIFIER | 10 | | | 29c. LICENSE NU | MBER | 29d, DATE S | IGNED (Month, Day, Year) |
| 5 5 3 M | TO B | MANUE AND ADDRESS OF PERSON WHO | ID | A | | D3370 | 0 | ▶ - | 30-96 |
| | | TED E. HO | COMPLETED CAUSE OF DE | 4.4 | Prim) ERLOOK | DR. | BOON | SBORO | AM |
| | | JAN 3 01396 | 32. REGISTRAR'S SIGN | | | | | | |



BALTIMORE, MARYLAND 21215-0020

1 -

DIVISION OF VITAL RECORDS, P.O. BOX 68760

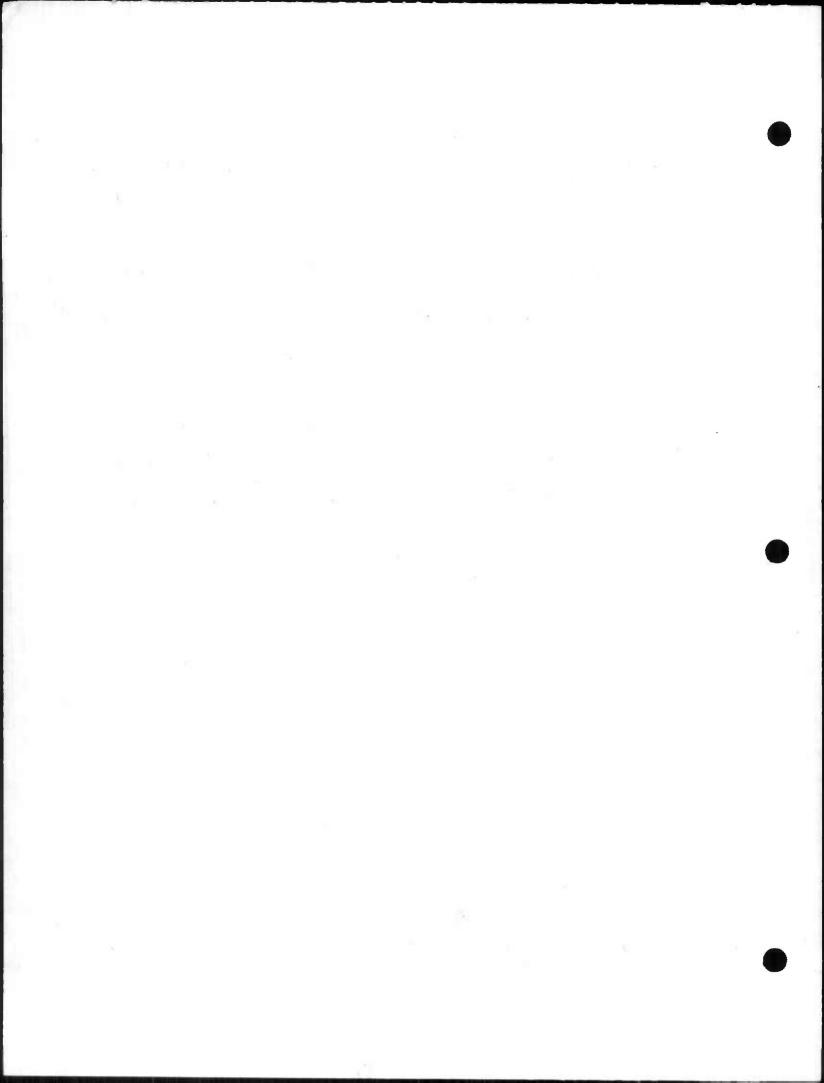
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE OF | DEATH | w | YEAR | . TIME OF DEATH |
|---------------|---|--------------------------------------|--------------------------------|---------------------|-------------|--------------------|---------------------|--------------------------|--------------|--------------------------|-----------------------------|------------|------------------------|----------------------------------|
| | | | RICHARD | A. P | ERRY | SR. | | | | JAN | | 19 | | 12:55 P.M |
| | 4. SOCIAL SECURITY NUMB | ER | 5. SEX (| 3. AGE (In yrs. las | birthday) | IF UNDER | | 1 | ER 24 HRS. | 7. DATE OF (Month, L | BIRTH | | a. BIRTHPI Country) | ACE (State or Foreign |
| | 226-30-3725 | 5 | 1 M 2 D F | 66 | YRS. | MONTHS | DAYS | HOURS | MIN. | | 11,1 | 930 | | MD. |
| | 9e. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY | TOWN | OR LOCA | TION OF DE | | | | NTY OF DEA | тн |
| OR | 6137 STEVE | | ET | | | SAI | LISE | URY | | | | W: | ICOMI | CO |
| DIRECTOR | RESIDENCE OF DEC | 10b. COUNTY | , | | 10c. CIT | Y, TOWN C | OR LOCA | TION | | | | | Ti | Od. INSIDE CITY |
| JIR. | MD. | | OMICO | | | SALIS | | | | | | | | LIMITS? |
| | 10e, STREET AND NUMBER | 11200 | 711100 | | <u> </u> | OVDIC | | f. ZIP CO | DE | | | 10g. CIT | | AT COUNTRY? |
| RA | 6137 STEV | E STRI | EET | | | | | 2180 |)1 | | | 1 | U.S.A. | 5.94 |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDENT | | | | | CENDENT | OF HISPAN | IC ORIGIN? | | | 14. RACE - | - American Indian. |
| | 1 Never Married 2 | | FORCES? 1 5 | | 10 | | | ecify Cui | | n, Puerto Ric y: | en, etc.) | | Specify: | White, etc. |
| ВУ | 3 Widowed 4 XDivo | rced | U.S. NAV | Y KO | REAN | | | | | | | | | WHITE |
| COMPLETED | | EDENT'S EDU y highest grade | | (G | ive kind of | USUAL O | CCUPATI during m | ON ost of wor | king | 16b, K | IND OF BUS | HNESS/IN | DUSTRY | 1 |
| <u>u</u> | Elementary/Secondary (0 | 1-12) | College (1-4 or 5+) | 100 | Do NOT u | | | | | | MI | DTOAT | | jan. |
| MP | | | | 0 | ptic: | lan | | | | | | DICA | L | |
| | 17. FATHER'S NAME (First, M EDWARD F | | | | | | | 18. MC | _ | ME (First, Mid A HORS | | Sumeme) | | |
| 8 | 190, INFORMANT'S NAME (| | | 100 | MAILING | AOODES | R /Stead | and Alumb | | A HUKS | | o Ctato 70 | in Cortel | |
| 2 | | PERRY | | | | | | | | FORD, I | | | | 100 |
| | 20e. METHOD OF DISPOSIT | | | 20b. PLACE | | | | | OLA. | DATE | 7 | | City or Town | n State |
| | 1 Donetton 6 Other | n 3 🗌 Rem | ovel from State | BIVA | matory or o | ther place) | CH C | FMFT | TERV | | BIV | | | |
| | 21. SIGNATURE OF FUNERA | | CENSEE | DIVE | 7 | | | | RESS OF FA | | LI DIA | ULVE | , MD. | |
| | * Suc | 111 | 1/1/2 | me X | | - BO | OUND | S FU | JNERA: | L HOMI | E.SAL | ISBU | RY, MD | 21804 |
| | 23. BART i. Enter the d | | | | | | | | | | - | | - | Approximate |
| | ahock, or h | | List only one caus | e on each line | h. | | | | | | | | | Onset and Death |
| | disease or condition | → | Lun | OR/AS A CONSE | n 10 0 - | | | | | | | | | |
| | resulting in death) | , | DUE TO (| OR AS A CONSE | DUENCE O | F): | | | | | | | | |
| z | | | b | / | | | | | | | | | | |
| 윤 | Sequentially list condit if sny, leading to imme | diate | DUE TO (| OR AS A CONSE | DUENCE O | F): | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLY CAUSE (Disease or Inju | | C | | | | | | | | | | | - |
| 1 | that initiated events resulting in death) LAS | т Т | DUE 10 (0 | OR AS A CONSE | DUENCE O | IF): | | | | | | | | |
| H | | | d | | | | | | | | | | | |
| | PART II. Other significa | ent condition | s contributing to c | seeth but not i | resulting | In the u | nderlyli | ng cous | e given in | Part i. 2 | 4a. WAS AN | | | WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | | | | | | YES 2 | X NO | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | / | | TO YES 2 NO |
| | DID TOBACCO U | ISE CONT | RIBUTE TO CAL | JSE OF DEA | TH Y | ES 🗆 | NO [| JUN | ICERTAI | N 🗆 | | | | / (|
| M | 25. WAS CASE REFERRED T | O MEDICAL | | 26. PLAC | E OF OEA | TH (Check | - |) | | | | | | |
| SIC | 1 VES 2 NO | | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE 4 Nu | R: reing Ho | me 5 K | Residence | 6 🗆 Other (| Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | Pending | 28e. DATE OF II (Month, De) | NJURY y, Year) | 28b. TIR | ME OF JURY M | W | JURY AT ORK? YES 2 | ! □ NO | 28d. DESC | RIBE HOW I | NJURY O | CCURED | |
| ED BY | | Investigation Could not be | 28e. PLACE OF building, a | INJURY — At ho | ome, ferm, | street, fac | tory, offi | ce | | | ION (Street Town, Stete) | | er or Rural Ro | ute Number, |
| | 4 Homicide | determined | | | | | | | | | | | | |
| COMPLET | Crieck only | TIFYING PHYS | ICIAN: To the best of r | ny knowledge, de | ath occur | red at the | time, de | e end pla | ice, end du | to the cause | e(e) end ma | nner as st | ated. | |
| O | one) /2 _ MED | HCAL EXAMINE | R: On the basis of exa | mination end/or | Investigati | on, In my | opinion, | death oc | cured at the | time, date e | nd place, er | nd due to | the ceuse(s) | and manner as stated. |
| BE | 29b. SIGNATURE OND TITLE | 296. SIGNATURE ON TITLE OF CENTIFIER | | | | | | 29c. L | ICENSE NU | MBER 9/0 | 5 | 29d, DA | TE SIGNED | Mongh, Day, West) |
| ٩ | 30. NAME AND ADDRESS O | F PERSON WI | O COMPLETED CAUSE | E OF DEATH (ITE | M 27) (Typ | e, Print) | n | 10 | 1 | 9/0 5+ | | 1 | 01 | - |
| | 31. DATE FILEO (Month, Day, | | 32. GEORSTRAF | 'S SIGNATURE | 10 | 06/ | 1/11 | 10 | rd | JT | ree | .T, \ | Ja 11. | sbury |
| | JAN : | luckier Ro | volally | | | | | | | | | , | | |



BALTIMORE, MARYLAND 21215-0020

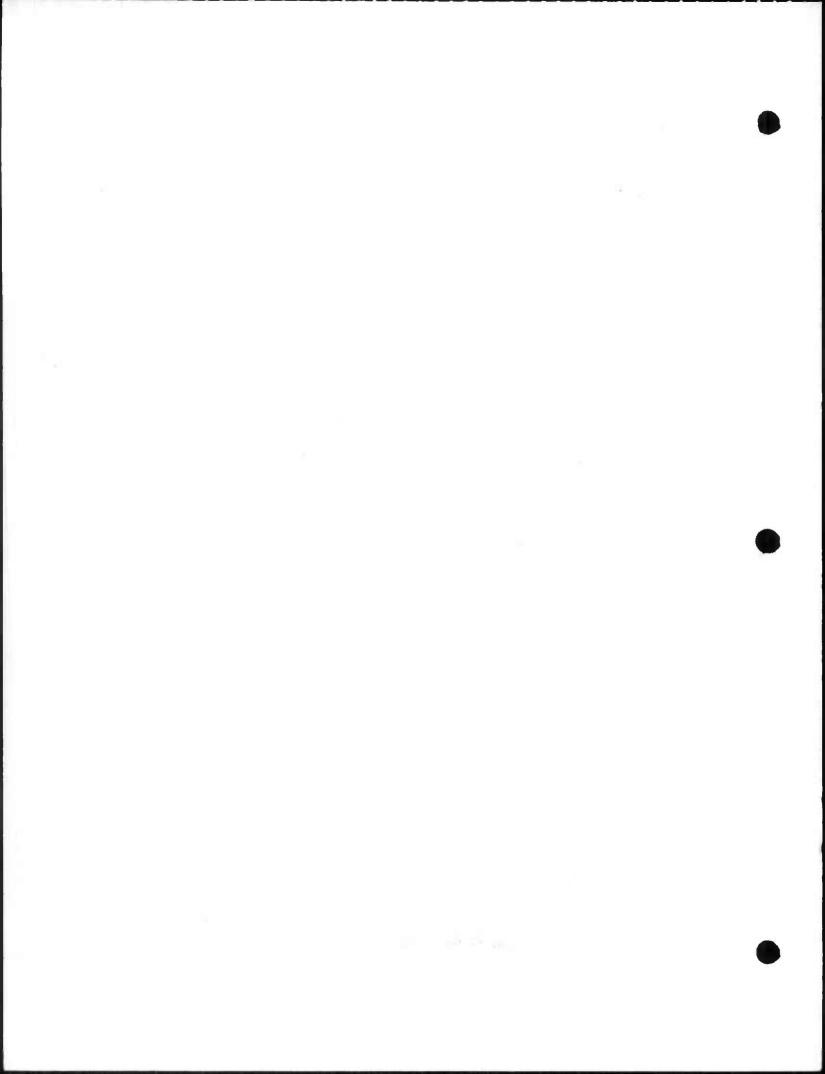
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE

| | HEGISTHAH | | | | CAIL | DE DEATH | _ | REG. NO. | | | |
|---------------------------------------|--|--|---|--|--|--|--|---|--|--|--|
| - 3 | 1. DECEOENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF | | | | TIME OF DEATH |
| - 8 | VEDNIONI | | DIMONIET I | | | | MONTH | 2/ | | EAR | |
| - 0 | VERNON | | PURNELL | | | | 01 | 20 |) 9 | 6 | 0710 M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (in yrs. last | | IF UNDER 1 YE | | 7. DATE OF | | 0. | BIRTNPL | ACE (Stata for Foreign |
| | 213-12-5464 | 1 K M 2 F | 70 | YRS. | MONTHS DA | YS HOURS MIN. | | Day, Year) | 1 | Country) | MM |
| | | | 72 | | | | | <u>19–23</u> | | | 1100 |
| _4 | 9e. FACILITY NAME (If not institution, give s | treet and number) | | | 9b. CITY, TO | VN OR LOCATION OF D | EATH | | 9c. COUNTY | OF OEAT | ΓN |
| ۱۳ | AUT ANDIC CONDOAT | | | | DEDT : | ENT | | | LIODOF | COOL | |
| DIRECTOR | ATLANTIC GENERAL | | | | BERL | LIN | | | WORCE | PLEK | |
| :: I | 10e. STATE / 10b. COUNTY | v . | 1 | 100 CITY | TOWN OR LO | CATION | | | | T.,, | |
| œ | -w./ | / | / | 100. 0111, | 2 | P | | | | 10 | Dd. INSIDE CITY LIMITS? |
| ᅙᅵ | 11/0, 100 | Orcesy | her | 1 | PADI | nl | | | | 1 | TES 2 NO |
| اپ | 10e. STREET AND NUMBER | | | , | U LL | 101. ZIP CODE | | | 10a CIT 17E | U OE WILL | AT COUNTRY? |
| ا ۾ | 10-10 -1 | | < 1000- | 1 | | | 1 | | log. Citta.Ei | // | II GOOMINI? |
| FUNERAL | 10340 110 | wer | STILL | 1 | | 2/8// | | | (| 1. | 7 . |
| 5 1 | 11. MARITAL STATUS | 12. WAS OECEDEN | IT EVER IN U.S. ARM | 4ED | 13. WAS | DECENDENT OF HISPA | NIC ORIGIN? | Specify Yee | or No. 14 | BACE - | American Indian, |
| | 1 Never Merried 2 Merried | FORCES? 1 | YES 2 NO | 0 | If yes | , specify Cuben Mexic | an, Puerto Ric | an, etc.) | | Bleck, V | Vhite, etc. |
| l a | 3 Widowed 4 Divorced | IF YES, GIVE V | WAR OR OATES | | 1 🗆 | YES 2 AND Speci | Hy: | | | Specify: | |
| | | 1 | | | | | _ | | | | BLACK |
| | 15. DECEDENT'S EDUC | | 18a. DEC | EDENT'S U | SUAL OCCUP | PATION | 16b, K | IND OF BUS | INESS/INDUS | TRY | |
| <u> </u> | (Specify only highest grade Elementary/Secondary (0-t2) | | life i | to NOT use | ork done dunn; retired.) | most of working | | , | / | 1 | 1 |
| <u> </u> | Flem. | College (1-4 or 5 | " | P | 1 | Rus [] | | /, | 1000 | 0101 | 160 1 |
| <u> </u> | Elemi | | 120/ | teny | royed | DUS CONTRA | actor | ~ | JUICE. | she | 3d. 9 Ed. |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | 7 | 1.1 | U | 0 | 18. MOTNER'S N | AME (First, Mid | idle, Meiden | Surname) | | |
| | Wilmer. G | · Pui | rnell | | | Alh | orta | - | Tono | 15 | |
| H | 00,00000 | | | | | TTID | 1700 | | Orie | | |
| 0 | 190. INFORMANT'S NAME (Type/Print) | n O. | // 19b. | MAILING A | ADDRESS (Str | eet and Number or Rural | Boute Number | City or Town | , State Zip Co | ide) | / |
| = | Lillie 11/0 | e jurn | 211 1 | 054 | 0 - | power St | reet | BI | rlin. 7 | mr. | 2/8/1 |
| - 1 | 20g. METHOD OF DISPOSITION | | | | | | | 1 20 10 | | 170.6 | |
| - 1 | 1 Duriel 2 Cremetion 3 Rem | ovel from State | 20b. PLACE AI cemetery, crem | natory or oth | er.placeV | N (Name of | DAJE | 20c. LO | CATION - CIT | or Toyn, | State |
| | 4 Donation 5 Other (Specify) | 1 1 | Ever | green | I GEN | ne tary | 1/26 | 150 | TIN, 1 | Y10. | 2.1811 |
| | 21. SIGNATURE OF FUNERAL PRINCE LA | ENSEE //_ | | | | E ANO ADDRESS OF F | ACILITY | 1 - | 11.150. | 1 / 2 | 10-0 |
| | // | 11 | | | | wis No 6 | | NIF | INEKI | 4-61 | +ome |
| | | \times / | | | 161 | 100 1 1 | 1-1 | Alis | burn. | mel | 2/801 |
| \dashv | 20 0000 5 5 1 1 1 1 | | | | | | | | 1, | 4.70 | 5/101 |
| - 1 | 23. PART i. Enter the diseeses, or of shock, or heert feilure. | Difference to the course the | t ceuced the dea | ith. DD no | ot enter the | mode of dying, suc | ch aa cardia | c or reapi | ratory arres | .1 | Approximate |
| - I | IMMEDIATE CAUSE (Finel | clot biny bile coc | rao Dii eeçii iiile. | | | | | | | | interval Between Onset and Death |
| - 1 | disease Dr condition | A DOUBLE TO | COL EDORA | 0 0 | DDTOM | COULT AD DE | CDACD | | | | Oliset and Death |
| - 1 | reaulting in death) | e. ARTERIC | SCLEROIT | .C CA | KDTOA | ASCULAR DI | SEASE | | | | |
| l | | DUE TO | (OR AS A CONSECU | UENCE OF) | : | | | | | | |
| z | | | | | | | | | | | |
| ਠ ∥ | Sequentially list conditions, | DUE TO | (OR AS A CONSEQU | JENCE OF | | | | | | | 1 |
| 7 | if any, leading to immediate | | | | | | | | | | i |
| . 7 | | | | | | | | | | | |
| 2 ∥ | CAUSE (Disease or injury | D | | | | | | | | | |
| FIC | CAUSE (Disease or injury that initiated events | с. | (OR AS A CONSEQU | UENCE OF) | : | | | | | | |
| RIFIC | CAUSE (Diseese or injury | с. | (OR AS A CONSEQU | UENCE OF) | | | | | | | |
| CERTIFICATION | CAUSE (Diseese or injury that initieted events | с. | (OR AS A CONSEQU | UENCE OF) | : | | | | | | |
| 5 | CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO | | | | ving ceuse given in | Part I 2 | 4. WAS AN | AHTTODEV | | TOE ALTONOU EMPLADO |
| 5 | CAUSE (Diseese or injury that initieted events | c. DUE TO | | | | ying ceuse given in | Part I. 2 | 4a. WAS AN | | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| 5 | CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO | | | | ying ceuse given in | | PERFOR | MED? | AM CC | MILABLE PRIOR TO OMPLETION OF CAUSE |
| EDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO | | | | ying ceuse given in | | | MED? | CO OF | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition | c. DUE TO d. se contributing to | deeth but not re | sulting in | the underl | | | PERFOR | MED? | CO OF | MILABLE PRIOR TO OMPLETION OF CAUSE |
| MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO d. se contributing to | deeth but not re | sulting in | the underl | | | PERFOR | MED? | CO OF | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition DID TOBACCO USE CONTE | c. DUE TO d. se contributing to | deeth but not re | sulting in | the underl | ☐ UNCERTAI | | PERFOR | MED? | CO OF | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART it. Other algorificant condition DID TOBACCO USE CONTI | DUE TO d. RIBUTE TO CA | deeth but not re | Sulting in | NO | UNCERTAI | N 🗆 | PERFOR | MED? | CO OF | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition DID TOBACCO USE CONTI | DUE TO d. RIBUTE TO CA | deeth but not re | Sulting in | NO | ☐ UNCERTAI | N 🗆 | PERFOR | MED? | CO OF | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| HYSICIAN: MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART it. Other algorificant condition DID TOBACCO USE CONTI | DUE TO d. RIBUTE TO CA MOSPITAL: 1 Inpetiant 2 2 28e. DATE OF | deeth but not re | H YES | the underl | UNCERTAL DONE Home 5 Residence | 6 🗆 Other (8 | PERFOR | MED? | OF OF | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| PHTSICIAN: MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 \(\to NO) 27. MANNER OF DEATN 1 \(\times \) Netural 5 \(\to \) Pending | DUE TO d. RIBUTE TO CA HOSPITAL: 1 □ Inpetiant 2 5 | deeth but not re | H YES | NO I (Check only to OTHER: 6 Nursing OF 28c. | UNCERTAI | 6 🗆 Other (8 | PERFOR | MED? | OF OF | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| PHTSICIAN: MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? YEY YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation | DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inputant 2 5/(Month, D | deeth but not re | Sulting in | NO I (Check only of the Nursing OF 28c. RY M 1 | UNCERTAI one) Home 5 Residence INJURY AT WORK? YES 2 NO | N | PERFORI | MED? X] NO | OF 1 | MILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| BY PHYSICIAN: MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? LYAMINER? LYAMINER OF DEATN 1 K Netural 5 Pending Investigation 3 Suicide 6 Could not be | DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 \$ 28e. DATE OF (Month, D) 28e. PLACE O | deeth but not re USE OF DEAT 28. PLACE ER/Outpetlent 3 (INJURY JOHN (Nor) FINJURY — At hom | Sulting in | NO I (Check only of the Nursing OF 28c. RY M 1 | UNCERTAI one) Home 5 Residence INJURY AT WORK? YES 2 NO | 6 Other (3 28d, DESCF | PERFORI | MED? | OF 1 | MILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| ED BY PHYSICIAN: MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART it. Other algnificant condition DID TOBACCO USE CONTI | DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 \$ 28e. DATE OF (Month, D) 28e. PLACE O | deeth but not re | Sulting in | NO I (Check only of the Nursing OF 28c. RY M 1 | UNCERTAI one) Home 5 Residence INJURY AT WORK? YES 2 NO | 6 Other (3 28d, DESCF | PERFORI | MED? X] NO | OF 1 | MILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| ED BY PHYSICIAN: MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART it. Other algnificant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WYES 2 \(\) NO 27. MANNER OF DEATN 1 \(\) Netural 5 \(\) Pending Investigation 2 \(\) Accident 3 \(\) Suicide 6 \(\) Could not be determined | DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 § 28e. DATE OF (Month, D) 28e. PLACE O building, | deeth but not re USE OF DEAT 28. PLACE ER/Outpatient 3 (INJURY Area, Year) FINJURY — At hometc. (Specify) | H YES OF DEATN DOA 26b. TIME INJU | NO I (Check only of the Norther: OTHER: | UNCERTAI UNCERTAI UNCERTAI UNCERTAI UNCERTAI UNCERTAI VALUE | 6 Other (S 28d, DESCE | PERFORI YES 2 Specify) RIBE NOW IN ION (Street e. Town, State) | MED? NO NUMBER OCCUP | AM CCC OF 1 | MILABLE PRIOR TO MPLETION OF CAUSE F DEATH? |
| ED BY PHYSICIAN: MEDICAL CE | CAUSE (Disease or injury that initiated events resulting in death) LAST PART it. Other algnificant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WYES 2 \(\) NO 27. MANNER OF DEATN 1 \(\) Netural 5 \(\) Pending investigation 2 \(\) Accident 3 \(\) Suicide 6 \(\) Could not be determined 29e. CERTIFIER (Check only) 1 \(\) CERTIFYING PNYSK | DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 § 28e. DATE OF (Month, D) 28e. PLACE O building, | deeth but not re USE OF DEAT 28. PLACE ER/Outpatlent 3 (INJURY Are (Specify) my knowledge, deat | Sulting in H YES OF DEATN DOA 26b. TIME INJU | NO I (Check only OTHER: 6 Nursing OF 28c, RY M 1 reet, factory, c | UNCERTAI UNCERTAI UNCERTAI UNCERTAI UNCERTAI UNCERTAI VES 2 NO Office | 6 Other (S 28d, DESCE | PERFORI YES 2 Specify) NIBE NOW IN ION (Street e Town, State) | MED? NO NUTRY OCCUP Ind Number or | AM CC OF | MILABLE PRIOR TO DMPLETION OF CAUSE DEATH? YES 2 NO |
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3. TIME OF DEATH

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10d. INSIDE CITY

1 YES 2 NO

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Onset and Death

8 DAYS

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30. NAME AND ADDRESS OF PERSON

JAN 30 1996

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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. DEGISTRAR'S SIGNATURE
Jalia Dauden-Randall

Injury, or other

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | = | 6 | ige. | 99 |
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writim 24 hours after di | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical as |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Julius Potosky Jan. 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F DAYS HOURS BARN YRS 578-09-3991 80 Feb. 1915 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Montgomery General Hospital Olney Montgomery 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Montgomery Potomac 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1540 Blue Meadow Road 20854 II. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 √ YES 2 NO IF YES, GIVE WAN OR DATES 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO 3 Widowed 4 Divorced Specify Specify: IIWW 16e. DECEDENT'S USUAL OCCUPATION

Work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sp (Give kind of work done during iffe. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nathan Potosky Fannie (Unknown) 19a, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Potosky 1540 Blue Meadow Rd., Potomac, MD 20854 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata 1 CBurial 2 Cremetion 3 Removal from State
4 Donation 8 Other (Specify) King David | 1 Falls Church, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, MD 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition TNeymonia resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSPOUENCE OF) resulting in dasth) LAST

| AN: MEDICAL | PART II. Other algoriticant condition I hrumbo cytype URGANIC BR DID TOBACCO USE CONTI | A.N Syndrome | | | | 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|-------------|---|--|------------------------|----------------|------------------|---|--|
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 28. PLAC HOSPITAL: | OTH | ck only one) | 7 | | |
| ву РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 1 Onpetient 2 ER/Outpetient 3 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 1 YES 2 NO | - | er (Specify) SCRIBE HOW INJURY OCCU | RED |
| ETED E | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, term, etreet, | actory, offica | 28t. LOI City | CATION (Street and Number of or Town, State) | r Rural Route Number, |
| COMPLE | 2 MEDICAL EXAMINE | CIAN: To the best of my knowledge, da R: On the basis of examination and/or | | | | | |
| | 296. SIGNATORE AND TITLE OF CERTIFIER | | | 29c LICENSE N | LIMBER | 204 DATE | PIONED WATER DEL MAIN |

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29d. DATE SIGNED (Month, Day, Year)

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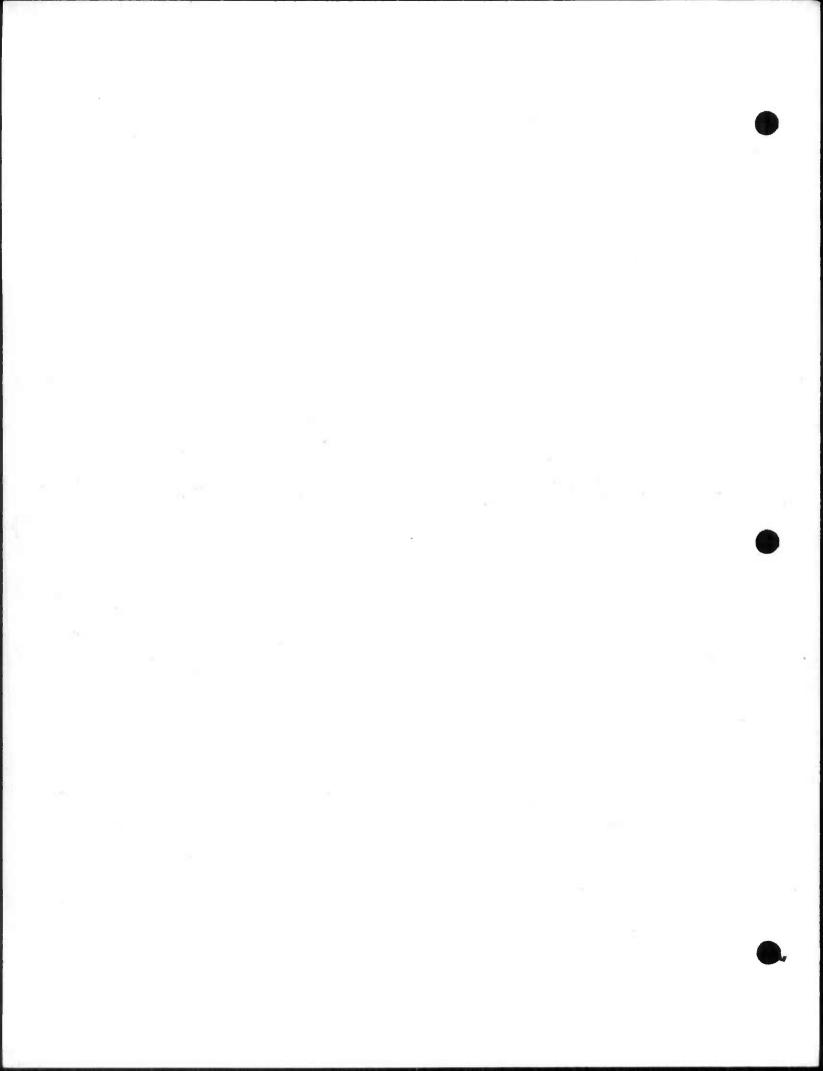
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without heart Plans and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF HEALT | | NTAL HYGIEN | | | | | | |
|---------------|---|--|---|-------------------------------------|----------------------------------|-------------------------------------|---------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. | DATE OF OEATH | | 3. TIME OF DEATH | | | | |
| | | Baby Boy Par | ng | | | | NAY YEA | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | - " | | DER 24 HRS. 7. | DATE OF BIRTH (Month, Day, Year) | 8. BI | RTHPLACE (State or Foreign | | | | |
| | | 1 M 2 □ F | YRS. | ONTHE DAYS HOUR | | | 1996 | Maryland | | | | |
| ~ | 9e. FACILITY NAME (If not institution, give s | | | b. CITY, TOWN OR LOC | | | 9c. COUNTY O | | | | | |
| DIRECTOR | Shady Grove Adver | atist Hospita | al | Rockvill | е | | Montg | omery | | | | |
| E C | 10e. STATE 10b. COUNTY | 1 | 10c. CITY, | TOWN OR LOCATION | | | | 10d. INSIDE CITY | | | | |
| H | Maryland Mon | tgomery | Roo | ckville | | | | LIMITS? | | | | |
| A A | 10e. STREET AND NUMBER | | | 10f. ZIP C | ODE | | 10g. CITIZEN C | OF WHAT COUNTRY? | | | | |
| FUNERAL | 501 Woodburn Road | d | | 208 | 51 | | Unite | d States | | | | |
| 12 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? 1 YES | N U.S. ARMED | 13. WAS DECENDEN | T OF HISPANIC O | RIGIN? (Specify Yes | or No — 14. R | ACE — American Indian, llack, White, etc. | | | | |
| ВУ | 1 Never Married 2 Merried 3 Widowed 4 Divorced | IF YES, OIVE WAR OR D | | 1 TYES 2 XX N | uben, Mexican, Pu NO Specify: | ierto Hican, etc.) | | anothe: | | | | |
| | 15. DECEDENT'S EDUC | CATION | 40- 0505051/510 110 | <u> </u> | | | | Asian | | | | |
| COMPLETED | (Specify only highest grade | completed) | (Give kind of wor life. Do NOT use r | k done during most of wo | orking | 166. KIND OF BU | SINESS/INDUSTR | Y | | | | |
| PL | Elementary/Secondary (0-12) | College (1-4 or 5+) | N/A | | | N/A | | | | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | 24/21 | 18, M | OTHER'S NAME (| First, Middle, Meiden | Surname) - | | | | | |
| BE C | Wei Jin Pang | | | | ao Yu L | | , | | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILINO AG | ODRESS (Street and Num | | | m, State, Zip Code, |) | | | | |
| F | Wei Jin Pang | | 501 Woo | odburn Roa | d, Rock | ville, M | laryland | 20851 | | | | |
| 1 | 20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Reme | oval from State | PLACE AND DATE OF | DISPOSITION (Name of place) January | 7 28 . 190 | DATE 20c, LO | CATION — City of | r Town, State | | | | |
| | 4 Donation 5 Other (Specify) | PIC | ontgomery | Crematori | um, Inc | . Det | | Maryland | | | | |
| | 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/Rockville, | | | | | | | | | | | |
| | Mufule | Shooms | M00846 | 300 West Rockville | Montĝon Marvl | ery Ayer | nue 350-2805 | Inc. | | | | |
| | 23. PART I. Enter the diseases, or of | complications that coused | the death. Do not | enter the mode of | dying, such as | | | Approximata | | | | |
| | MANEDIATE CAMEE (EL-) | | | | | | | Interval Between Onset and Death | | | | |
| | disease or condition resulting in death) | previable - | - prematu | rity | | | | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| NO N | Sequentially list conditions, | | perinatal asphyxia 1.21 mm | | | | | | | | | |
| 'ATI | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| 띪 | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | 1 | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | | |
| | PART II. Other algolificent condition | e contributing to death b | and more than to | | | | | | | | | |
| SP | TAIT II. Ottor aignincom condition | E continuoting to death o | at not resulting in | me underlying ceus | e given in Part | I. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | |
| MEDIC | | | | | | 1 YES 2 | ! □ NO | OF DEATH? | | | | |
| Σ | DID TOBACCO USE CONTE | PIRITE TO CALISE O | E DEATH VEC | | ICEDTAIN F | _ | H | 1 TES 2 NO | | | | |
| N¥ | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH | | ICEKIAIN L | | | | | | | |
| S | EXAMINER? | HOSPITAL: | 0 | THER: | | -7510 TU | | | | | | |
| PHYSICIAN: | 27. MANNER OF OEATH | 28e. DATE OF INJURY | 28b. TIME C | F 28c. INJURY AT | | . DESCRIBE HOW I | NJURY OCCURED | | | | | |
| ВУ Р | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUR | WORK? M 1 VES 2 | ! □ NO | | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, stre | et, lectory, office | 281. | LOCATION (Street | and Number or Rur | ral Route Number, | | | | |
| COMPLETED | 4 Homicide determined | | | | | City or Town, Stete) | | | | | | |
| 7 | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of my knowl | ledge, death occurred a | nt the time, date end pla | ice, end due to th | e ceuse(s) end mar | nner as stated. | | | | | |
| OM | | R: On the beels of examination | | | | | | e(s) and manner ee stated. | | | | |
| | 295. SUMATURE AND TITLE OF CERTIFIER | 011, | 11 | 29c. L | ICENSE NUMBER | | 29d. DATE SIGN | IED (Month, Day, Year) | | | | |
| O BE | Monspake | afferd | on M | | 36543 | | ▶ Jan. | 24, 1996 | | | | |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | | | |
| | CHRISTOPHER HULTZ | EN, MD, 9901 | | CENTER DRI | IVE, ROO | CKVILLE, | MD 208 | 850-3395 | | | | |
| | JAN 30 1996 | July Mudle | ATURS | | | | | | | | | |
| | 07111 0 0 1330 | June 10 months | - Magazi | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunia-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 -

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| ł | 1. DECEDENT'S NAME (First, | Middle, Last) | | | - | | | | | | 2. DAT | E OF DEATH | AV | YEAR | 3. TIME OF DEATH | |
|---------------------------------------|--|-------------------------|------------------------------|-------------|--------------|---|--------------|--------------|----------------------|-----------|------------|---------------------------------|-------------|--------------|--|--|
| | Jerry Aloysious OUADE | | | | | | | | | | | Jan. 28 1996 10:40 Am. | | | | |
| | 4. SOCIAL SECURITY NUME | BER | | | (In yrs. las | | | YEAR DAYS | IF UNDER | 24 HRS. | 7. DAT | E OF BIRTH | , | 8. BIRTHE | PLACE (State or Foreign | |
| | 220-88-020 | | 1X M 2 - F | | 38 | YRS. | | 111 | 100000 | 2.5 | Nov | | 1957 | M | laryland | |
| ا ي | 9e. FACILITY NAME (If not in | | , | | | | | | OR LOCATIO | ON OF DE | EATH | | | NTY OF DE | | |
| DIRECTOR | 706 West W | | ton Stre | <u>et</u> | | | Hage | ers | town | | | | Wa: | shing | ton | |
| <u>۾</u> | 10e. STATE | 10b. COUNTY | 1 | | | 10c. CITY | TOWN OR | LOCAT | TION | | | | | | 10d. INSIDE CITY | |
| | Maryland | Wash | ington | | | Ha | igers: | tow | ın | | | | | | 1 X YES 2 NO | |
| BY FUNERAL | 10e. STREET AND NUMBER | | | | | | | 101 | f. ZIP CODE | | | 10g. CITIZEN OF WHAT COUNTRY? | | | HAT COUNTRY? | |
| | _706 West W | ashing | | | | | | | 2174 | | USA | | | | | |
| 교 | 11. MARITAL STATUS 1 Never Merried 2 X | Merried | 12. WAS DECEDEN FORCES? 1 | YES | 2 X N | MED | If y | 4s, sp | ecify Cuber | n, Mexica | n, Puerto | IN? (Specify Ye Ricen, etc.) | e or No— | Black, | — American Indian, White, atc. | |
| B | 3 Widowed 4 Divo | | IF YES, GIVE V | WAR OR D | ATES' | | 1 [| YES | 2 X NO | Specify | y: | | | Specif | White | |
| | | EDENT'S EDU | | | 18e. DE | CEDENT'S L | JSUAL OCC | UPATIO | ON ost of working | _ | :10 | b. KIND OF BU | SINESS/INI | DUSTRY | | |
| COMPLETED | Elementary/Secondary (0 | | College (1-4 or 5 | +) | life. | Do NOT use | retired.) | ing mo | ost or working | 9 | | | | | | |
| M M | 9 | | | | A | djust | er | | | | F | Retail | Tire | Sale | S | |
| 8 | 17. FATHER'S NAME (First, M | | | | | | | | | | | , Middle, Maider | , | | | |
| BE | Phillip R | | Quade, S | r. | | Catherine Louise Burch 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 2 | Tina Helen | | ^ | | | | | | | | | | | | MD 04740 | |
| | 20e, METHOD OF DISPOSIT | | <u>e</u> | 201 | | VO W | | | | con | | et Had | erston - | | | |
| | 1 Burlel 2 Cremetle 4 Donetion 8 Other | on 3 🗆 flam | ovel from State | can | netery, cre | matory or oth awn Me | morial | Pa | | lan | 1 | 1996 Wil | | | | |
| | 21. SIGHATURE OF FUNERA | SERVICE NO | ENSEE | / | CCITI | QIVII I I | 22. NA | ME A | ND ADDRES | S OF FA | CILITY | | | | | |
| | >///lofo | 1/// | 1-0X-el | no | | | - | |)RNE FL | | | | | | D. 21795 | |
| | 23. PART I. Enter the disesses, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, Approximate Interval Batween | | | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Fine) | | | | | | | | | | | Onset and Death | | | | |
| | disease or condition Prain Metastasis. 4 Weeks | | | | | | | | | | | | | | | |
| _ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, DUE TO (OR A A CONSEQUENCE OF): H MONTH! | | | | | | | | | | | | | | | |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | if sny, laeding to immediata cause. Enter UNDERLYING | | | | | | | | | | | | | | | |
| | CAUSE (Disease or Injury that Initiated events Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| Ä | resulting in deeth) LAS | | d | | | | | | | | | | | | | |
| | PART ii. Other algnifica | ant condition | s contributing to | deeth b | out not r | eculting l | n the unde | ərlyin | g cause g | jivan in | Part I. | 24a. WAS AI | | 24b. | WERE AUTOPSY FINDINGS | |
| 2 | | | | | | | | | | | PERFORMED? | | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEDICAL | | | | | | | | | | | | | 1-1 | | 1 YES 2 NO | |
| Z | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | | | | | |
| SI | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | | | | | | | |
| PHYSICIAN: | 1 TYES 2 NO | | 1 Inpetient 2 | ER/Out | petient 3 | □ DOA | OTHER: | g Hon | no 5 / Ra | eldence | 8 🗆 Oti | her (Specify) | | | | |
| H | 27, MANNER OF DEATH | Pending | 28e. DATE OF (Month, L | | | 26b. TIME INJU | | WC | JURY AT DRK? | | 28d. D | ESCRIBE HOW | INJURY OC | CURED | | |
| B | 2 Accident | Investigation | 26e. PLACE (| NE IN ILIEN | d At ho | | M I | 1 | | NO | 004.17 | CATION (Street | and Manha | 0 0 | | |
| COMPLETED | 3 Suicide 6 4 Homicide | Could not be determined | | atc. (Spe | | me, term, s | reet, tector | y, ornic | | | | ly or Town, Stell | | r or Hurai H | oute Number, | |
| ا ۳ | 29e. CERTIFIER CERT | TIFYING PHYSI | CIAN: To the best o | t my know | vledga, da | eth occurre | d at the tim | e, date | e end place, | and due | to the c | ause(s) end me | nner ee ate | ted. | | |
| ≅ | Ome) | ICAL EXAMINE | R: On the beals of e | xaminatio | on end/or | investigation | n, in my opi | nlon, c | death occur | ed at the | time, da | ite and place, a | nd due to t | he cause(a) | and manner as stated. | |
| | 295, SIGNATURE AND TITLE | OF CERTIFIE | R. | | / | | | | 29c. LICE | NSE NU | MBER | | 29d. DA1 | E SIGNED | (Month, Day, Year) | |
| BE | Houd | 1 | Low | ~ | 100 | ~ 1 | MI) | | DH | 16 | 47 | 3 | • | 1/29 | 196. | |
| 임 | 30. NAME AND ADDRESS O | F PERSON WH | O COMPLETED CAU | SE OF DE | EATH (ITE | M 27) (Type, | | | 1- | | | | | / | | |
| | | | 363 S. C1 | evel | and | Ave. | Hag | ers | stown | , MD |). 2 | 1740 | | | | |
| | 38916 Z'14AC | Stear) Sale | REDISTR. | SI SI | ATURE | | | | | | | | | | | |
| | | U | | | | | | | | | | | | | | |

use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY. TOWN OR LOCATION OF DEATH CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY Calvert MD North Beach FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 3806 6th Street 20714 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried 1 YES 2 NO Specify: BY 3 ₩ Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only his Elementary/Secondary (0-12) College (1-4 or 5+) detached for Supervisor once. 17. FATHER'S NAME (First, Middle, Last) funeral director, page 5 should be 76 Arthur G. Bradley BE notified 19e. INFORMANT'S NAME (Type/Print) 2 Stephen J. PO Box 215, North Beach, MD Keefe hours after death. Page 6 may be Pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must Burlei 2 Cremetion 3 Removal from State Cem. Donation 5 Other (Specify) SIGNATURE OF FUNDRAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY n by the I 25. PART I. Enter the diseases, or complications that cadsed the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, ehock, or heart failure. List only one cause on each line. medical completely filled in by IMMEDIATE CAUSE (Final the disease or condition a. multiple organ tailure DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) executed within event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 and com metastatic bladder cancer DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditiona, 2 if sny, leading to immediate ceuse. Enter UNDERLYING DR ATTENDING PHYSICIAN: The law requires that the death certificate be other t CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in desth) LAST 6 PART il. Other significant conditions contributing to deeth but not reculting in the underlying cause given in Part i. MEDICAL s been signed by the pt. of Health and I any shows : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN certificate has been the State Dept. (PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA 1 YES 2 NO 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, this (1 Natural 5 Pending Investigation 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) DIRECTOR: A'
L hours after d
I Nem 28 Is 3 Suicide 8 Could not be determined COMPLETED 29e. CERTIFIER

**Chack only

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner as stated. TO THE HOSPITAL D
TO THE FUNERAL DI
De filed within 72 ho
IMPORTANT: If Its 2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner es atteted. 29h SIGNATURE AND TITLE OF CERTIFIES BE 2 E AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31, DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

1996

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

577 18 8687

GLADYS CECELIA REYNOLDS

1 🗆 M 2 😾 F

6. AGE (In yrs. last birthday)

Daviden Rarlall

86

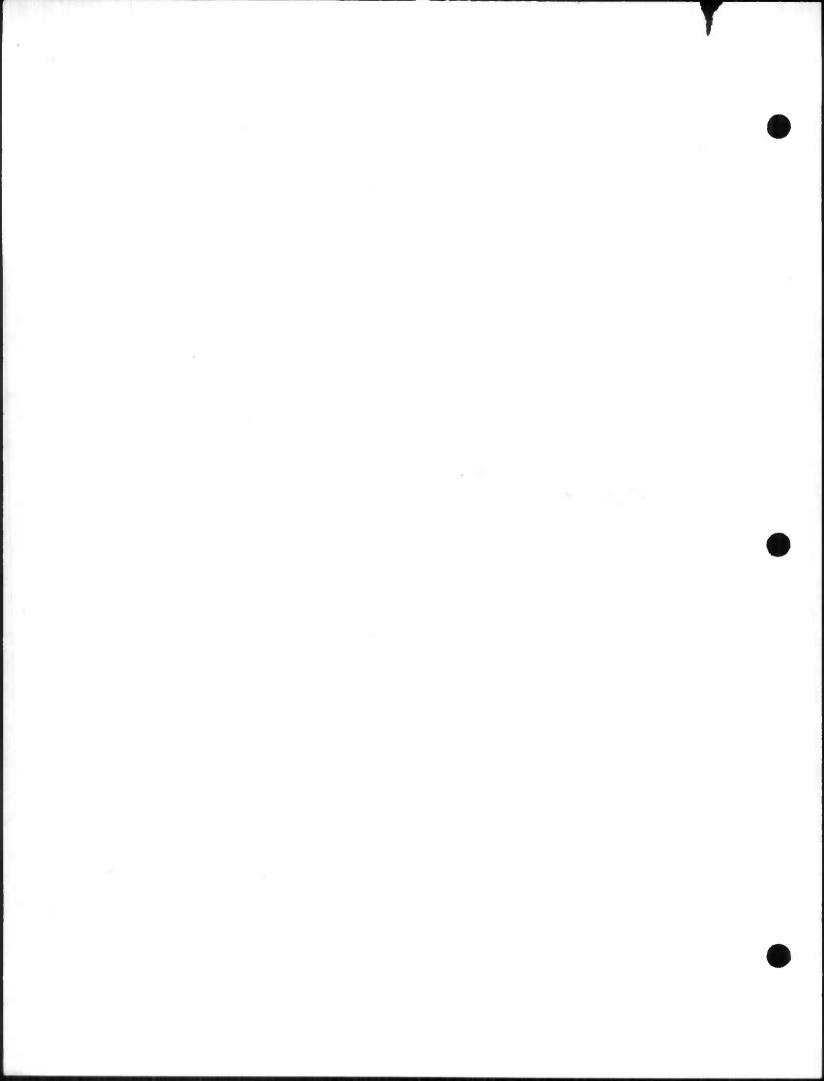
IF UNDER 1 YEAR

96 03819

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH 3. TIME OF DEATH YEAR 1996 0415 JANUARY 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (Stete or Foreign IF UNDER 24 HRS. 09 24 Nov. Wash.,DC 9c. COUNTY OF DEATH CALVERT 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, atc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.) white Specify 18b. KIND OF BUSINESS/INDUSTRY US Gov't. 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie C. Hooper 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20714 DATE 20c. LOCATION - City or Town, State 1-31-96 Suitland, MD Rausch Funeral Home, Owings, MD 20736 Approximate Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | 10 1 YES 2 NO OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stetn) 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

DHMH-16 Ray 1/89

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Pages 1, 2, 3 should

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completely filled in by the funeral director, page 5 should be detached for

burial,

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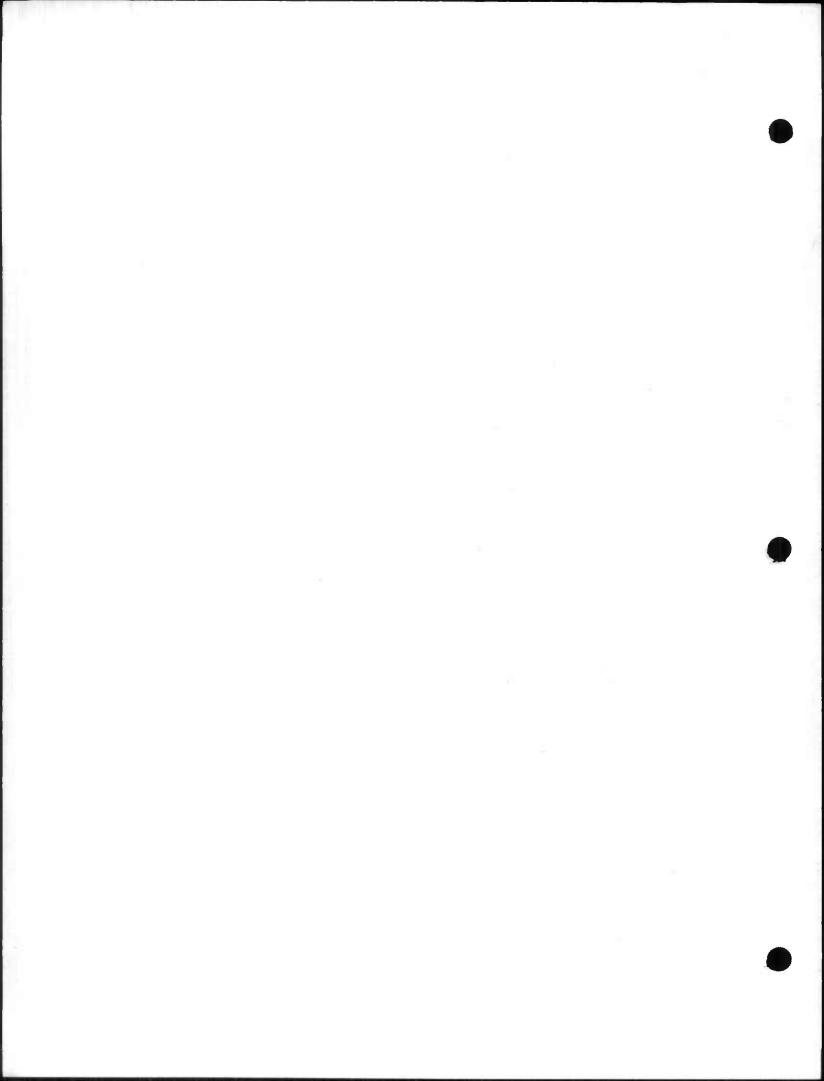
the attending physician 1 Mental Hygiene prior to

of Health and A

and

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 308 Elizabeth Mav 1996 Reese January 29 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. S. BIRTHPLACE (State or Foreign Country) DAYS 1 M 2 X F 219-34-4291 76 Sept.30,1919 Maryland Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Carroll County General Hospital Westminster Carrol1 RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Union Bridge 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11142 Green Valley Rd. 21791 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 X NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried Specify: BY 3 🕅 Widowed 4 🗌 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 4 dairy farm wife ONCE. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Herbert L. Bollinger Elsie Mae Shipley notified at 18a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 2 Robert L. Reese 205 Lambert Ave. New Windsor, MD 21776 Pe 20e. METHOD OF DISPOSITION
1 🖾 Burlal 2 🗆 Cremation 3 🗀 Ramoval from Stata
4 🗎 Donation 5 🗀 Other (Specify) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Pipe Creek Cemetery 2/1 nr. Linwood, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons Union Bridge medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heert fellure. List only one ceuse on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final traumatic event, the disease or condition_ resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury other t DUE TO (OR AS A CONSEQUENCE OF). that initiated eventa reaulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO MEDICAL shows any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? u r this certificate has been sit h with the State Dept. of He arked, or Item 23 show 1 YES 2 NO YES | NO | UNCERTAIN | PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 Residence 1 YES Inpatient 2 - ER/Outpatient 3 - DOA or o 27. MANNES OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF marked, 1 Matural 5 Pending E FUNERAL DIRECTOR: After this distribution of within 72 hours after death wertant: If item 28 is marks BY Investigation 2 Accident 26e. PLACE OF INJURY - At home, ferm, etraaf, factory, office 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated. TO THE HOSPITA TO THE FUNERAL De filed within 72 IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED AUSE OF DEATH (ITEM 27) (Type, Print)



detached for use as the burial-transit permit. Pages 1, 2, 3 should

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31. DATE FILED WAN

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| HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained | FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should | |
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STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF OFATN Bernadette Μ. Roxburgh January 24, 1996 2315 7. DATE OF BIRTH
(Month, Day, Year)
March 26, A. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 68 HOURS 119-22-8307 1 M 2 K F New York 1927 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Medpointe E1kton Cecil DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a STATE 10b. COUNTY 10d. INSIDE CITY Maryland Cecil Chesapeake City 1 YES 2 X NO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10e. STREET AND NUMBER 10f. ZIP CODE 5 Fern Drive 21915 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 ☐ YES 2 X NO Specify: 1 Never Married 2 X Merried IF YES, GIVE WAR OR DATES Specify: White ВУ 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade of Elementary/Secondary (0-12) College (1-4 or 5 +) 12 n/a Homemaker notified at once, 18. MOTHER'S NAME (First, Middle, Meiden Surname) 17. FATHER'S NAME (First, Middle, Last) George Shaw Lillian Sharrott BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21915 5 Fern Drive - Chesapeake City, MD Robert W. Roxburgh pe 20e METNOD OF DISPOSITION
1 (Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) PATE 7 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must "Bethel" Cemetery Chesapeake City, MD 1996 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY HICKS Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. medical Interval Between IMMEDIATE CAUSE (Final the disease pr condition NEUMO NIA resulting in death) or other traumatic event, OUE TO (OR AS A CONSEQUENCE DF): PHYSICIAN: MEDICAL CERTIFICATION Sequentisliy list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING entre Ulcer CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that Initiated eventa resulting in death) LAST Dept. of Health and Mental 23 shows any Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 XNO OF DEATN? 1 TYES 2 NO YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 28. PLACE OF DEATH (C 25. WAS CASE REFERRED TO MEDICAL State EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 the 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED WITH marked, INJURY Netural 5 Pending Investigation 1 YES 2 NO BY death 2 Accident 28e. PLACE OF INJURY - At home, term, street, tectory, office 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be determined COMPLETED after TO THE FUNERAL DIRECTOR be filed within 72 hours after IMPORTANT: If item 28 29s, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as attated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 30h, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 33510 223 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

641600

e a real man and a sept of the

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE | 0F | MARYLAND / | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYG | IEN |
|-------|----|------------|-------------------|----|---------------|-----|---------------|------|-----|
| | | C | ERTIFICATE | 0 | F DEAT | TH | | REG. | NO. |

| • | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | MENT OF H | | MENTAL HYGIEN | | | |
|------------------|---|---|----------------------|---------------------------------|----------------------|---|------------------|---|--|
| i | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | | 3. TIME OF DEATN | |
| | CHARLO | TTE ROSS | | | | JAN 26 1 | | 2:50 am M | |
| 1 | Final services resistant | | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. | BIRTNPLACE (State or Foreign Country) | |
| | 220-04-563] 9a. FACILITY NAME (If not institution, give street | M 2 F 69 | YRS. | | R LOCATION OF DE | SEPT. 5 1 | | | |
| DIRECTOR | ANNE ARUNDEL MEDIC | AL CENTER | | ANNAPO | | | ANNE | ARUNDEL | |
| E C | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | |
| PIG | MARYLAND ANNE A | RUNDEL | ANNA | POLIS | | | | 1 X YES 2 NO | |
| AL | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| FUNERAL | 40 COLLEGE CREEK | TERRACE | <u></u> | | 21401 | | USA | | |
| 5 | 11. MARITAL STATUS 12 1 Never Married 2 Married | . WAS DECEDENT EVER IN FORCES? 1 YES | | | | IIC ORIGIN? (Specify Yen, Puerto Rican, etc.) | a or No— 14. | . RACE — American Indien, Black, White, etc. | |
| ВУ | 3 Widowed 4XXDivorced | IF YES, GIVE WAR OR DAT | TES TA | | ZXXNO Specify | | | Specify: BLACK | |
| | 15. DECEDENT'S EDUCATION | ON | 16a. DECEDENT'S U | | | 16b, KIND OF BL | ISINESS/INDUS | | |
| E | (Specify only highest grade com Elementary/Secondary (0-12) C | ollege (1-4 or 5 +) | (Give kind of wo | ork done during mo retired.) | st of working | | | | |
| MPL | 11th | 0 | HOMEMA | KER | | OWN | HOME | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTNER'S NA | ME (First, Middle, Maider | Sumame) | | |
| BE | JOHN HENDERSON | | | | | LE JONES | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tox | | | |
| | CHARLES ROSS 200. METHOD OF DISPOSITION | | | | | | | MD. 20772 | |
| | 1 Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | from State ceme | PLACE AND DATE Of | er place) | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | | NAPOLIS 1 | 22. NAME AN | D ADDRESS OF FA | 1/31/96 A | | IS,MD. | |
| ; | Lary & Reese | | | | | MORTUARY, | | 1401 | |
| Ì | 23. PART I. Enter the diseases, or com shock, or heart failure. Liet | plications that caused | the deeth. Do no | ot enter the mo | de of dying, suc | h as cardiac or resp | olratory arrest | t, Approximata | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Intra | web | val | Der | norrhe | 192 | Onset and Death | |
| ŀ | | DUE TO (OR AS A | CONSEQUENCE OF | 1 1 | 4 | | 1 | no t | |
| NO | Sequentially list conditions, 6. | Uncon | CONSEQUENCE OF | d A | poul | err | | degra | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | DOE 10 (ON AS A | CONSEQUENCE OF | • | 1 1 | | | / | |
| FI | CAUSE (Disease or Injury that initiated evente | DUE TO (OR AS A | CONSEQUENCE OF | : | | | | | |
| TH. | resulting in death) LAST | | | | | | | | |
| | PART ii. Other algnificant conditions c | ontributing to death by | it not requiting is | the underlying | a cause alven in | Part I. 24s, WAS A | MALITOREY | 24b. WERE AUTOPSY FINDINGS | |
| CAL | | onthouting to equal by | it not recoiting in | i the underlying | g cause given in | PERFO | RMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE | |
| ED | | | | / | | 1 [] YES | 2 (A) | OF DEATH? | |
| Σ | DID TOBACCO USE CONTRIB | LUTE TO CAUSE OF | F DEATH YE | S NO F | UNCERTAI | <u> </u> | | 1 TES 2 NO | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | 6. PLACE OF DEAT | | J OTTOLIKI III | | | | |
| SIC | | OSPÍTAL: | itlent 3 🗆 DOA | OTHER: 4 Nursing Horr | e 5 Residence | 8 Other (Specify) | | | |
| Ή | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c, INJ | | 28d. DESCRIBE NOW | INJURY OCCUP | RED | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | YES 2 NO | | | | |
| ED | 3 Suicide 8 Could not be | 28a. PLACE OF INJURY building, atc. (Speci | — At home, ferm, at | reet, factory, offic | • | 281. LOCATION (Street City or Town, State | | Rural Route Number, | |
| E | | | | | | | | | |
| APL | 29a. CERTIFIER (Check only one) | | | | | | | | |
| COMPLET | 2 MEDICAL EXAMINER: C | On the basis of axemination | and/or Investigation | i, in my opinion, d | leath occured at the | tima, data and place, a | and due to the c | cause(a) and manner as stated. | |
| BE | 29b. SIGNATURE AND TITLE OF CENTIFIER | all. | | | 29c. LICENSE NUI | 1216 | 29d. DATE S | GIGNED (Month, Day, Year) -26-96 | |
| 0 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, | 204 | Wes | + St. | Asu | apolis Md | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | | | | | 1 | |
| | IAN 2 9 1006 | J. A. Asurles | whatall | | | | | ₹ | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are I adhla

State of Maryland / Department of Health and Mental Hygiene 96 03823

| _ | | | | | | Cen | tificate of | Death | | Reg. No. | | |
|----------------------------|--|------------------|---|---|-------------------|----------------------|--------------------------------------|------------------------------|--|------------------------------------|------------------------------|---|
| | Dhuolei | 20 | 1. Decedent's Neme (First, Middle, Last) |) A 11 1 a | MS 5 | 0 1 | 201/2 | 100 | 2. Dete o | Day | Yeer | 3. Time of Death |
| | Physici /Medic | | BARBAR | | 1152 | Kt | -CKN | 1FK | JANI | | H 1996 | 10:40 PM |
| | Examir | er | 4e. Fecility Neme (If not institution, give si | | | | | 4b. City, To | wn, or Location of D | eeth 4c. Count | ty of Death | |
| | | | North Arundel Hosp | | | | If Under 1 Year | | Burnie | | e Arur | |
| Н | Funeral Director | | 5. Sociel Security Number 6. Sex | M ACKE | (In yrs. last bii | thday) Yrs. | Months Deys | | Min. (Month | Birth Dey, Year) | | ilece (State or Foreign try) |
| Н | | | 219-16-0721 Usuel Residence of Decedant | 72 | | | | | Oct / | 1923 | Maryl | land |
| | yland | | 10e. Stete 10b. County | | 10c. City, Tow | n or Loc | ation | | | | 10 | Od. Inside City Limits |
| | Mar Mar | ctor | MD Anne Arun | de1 | ΔΥι | nold | | | | | | 1 ☐ Yes 2 ☐ No |
| | or 28 | Oire | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Coun | itry? |
| | 23e | Funeral Director | 1105 Silverleaf D | rive | | | 210 |)12 | | United | 1 Stat | es |
| | tame tame | une | | Wes Decedent Ev Armed Forces? | | 13. W | es Decedent of I Yes, specify Cub | Hispenic Orlean, Mexican | gln? (Specify Yes on, Puerto Rican, etc. | | eca - America eck, White, | |
| 20 | s afte | by F | 1 Never Merried 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes XX No If Yes, Give |) | 1 | □Yes 2 No | Specify: | | Speci | fy: W1- | nite |
| Maryland 21215-0020 | permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Haulh and Mental Hyglana. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other traumatic evant, the Medical Examiner must be notified at PARCE. | ed t | 15. Decedent's Educ | Yeer or Detes: | 16e | Decede | ent's Usuel Occu | petion | | 16b. Kind of 8 | | |
| 215 | n" n | Completed | (Specify only highest grade | completed) | | (Give k | ind of work done O NOT use retire | durina mosi | t of working | 100,11110011 | 7000110001110 | |
| 212 | d with | E O | Elamantary/Secondary (0-12) | College (1-4or 5+) | , | Lib | rarian | | | Defens | se Ind | lustry |
| pu | e file al Hy othe vant | Be | 17. Fether's Neme (First, Middle, Last) | | | | | 18. Mothe | er's Neme (First, Mid | | | |
| yla | Ment Ment arked | Tol | Richmond B. Holmes | | | | | | Lelia T | a11 | | |
| Jar | 2 sh and ls m raum | | 19e. Informent's Neme/Reletionship (Typ | e, Print) | | | | | er or Rural Route No | | | |
| 6,1 | l and faalth m 27 ther t | | Carroll L. Denson | | | | Silverle | eaf Dr | ive Arnol | | | |
| Baltimore, | nt of h | | 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Re | movei from Stete | cemete | ry, crem | etory or other ple | , | Dete | 20c. Location | - City or To | wn, Stele |
| 를 | it. Parture | | 4 ☐ Donetion ²⁵ ☐ Other (Specify) 21. Signeture of Funerel Service Licenses | | Ft. Li | nco | In Crema | tory | 1/30/96 | Brenty | vood, | Maryland |
| Ba | Depariment Important Irraporta | | 21. Signature of Furier of Service Cicerises | | | 1/ | 7 Dules o | oss or recini | John M. T ucester S | aylor Fur | neral | Home, Inc. |
| | | | 23a. Pert1. Enter the disease, or complic | etions that caused the | he deeth Do | | | | | - | TIE, | Approximate |
| | Physician | | shock, or heart fellure. List only one | ceuse on each line |), | | | | | ,, | | interval Between Onset end Death |
| r | /Medical | | immediete Cause (Final disaase or condition | BRAL | M M | ET | ASTAS | ES | | | i | MONTH. |
| п | Examiner | | resulting in deeth) e. | | ue to (or es e | | | | | | | |
| | D # | iner | a b | LUT | 100 | CA | NCER | | | | - | 2 YEARS |
| | ertificata be axecuted ling physician and a as the bunal-transit | edical Examiner | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying | D | ue to (or es a | consequ | ance of): | | | | | |
| 68760, | be a | alE | cause. Enter Underlying Cause (Disease or injury thet initiated evants | | | | | | | | i | |
| 687 | ficate physical ps the | edic | resulting in death) Lest | Di | ue to (or es a | consequ | ance of): | | | | 1 | |
| × | 0 2 8 | M | d. | | | | | | | | i | |
| . Bo | The law requiras that the death ata has been signed by the atter paga 2 should be detached for r | Physician | Pert ii. Other algnificant conditions contr | ributing to death but | not resulting i | n the un | derlying causa gi | van in Pert I | . 23b. | Otd tobacco use c | ontribute to | the cause of death? |
| P.0. | by the | Phy | TWEAKNESS SECO | | | | | | | Yes 2 No | 3 Prot | bebly 4 Unknown |
| | as the | by | DULTINIL 33 3LC | 31441111 | 10 0 | LNI | 201001 | 1004 | - | | | |
| ord | v require | sted | EVENT | | | | | | | Ves en autopsy performed? | eva | ere autopsy findings alleble prior to mpletion of cause |
| Sec | law has b a 2 s | Completed | A HYPERTENSION | | | | | | | ~ | of | deeth? |
| a | ician: The lav certificata has rector, paga 2 | | | | | | | | 1 | □ Yes 2000 | 16 | JYes 2□No |
| <u> </u> | certifi | Be C | 25. Wes case referred to medical examiner? | spital: | | 0.57.510 | Ot | hor | of Deeth (Check o | | | |
| of | Phys r this aral di | 7: To | 1 Yes 2 No | 1 Inpatient 28a. Dete of Injury | 28b. | itpatient Time of | 3□ DOA 28c. inju | 4 LI NU | rsing Home 5 F | lesidence 6 LO | | 0 |
| Division of Vital Records, | or Attending aftar daath. Director: Aftar d in by tha funa | Certification: | 1 Naturat 5 ☐ Panding investigation | (Month, Day | Year) i | njury | | ork?]Yas 2.⊟i | | | | |
| VIS | aftar daath Director: A I in by tha f | tiffe | 3 Suicide 6 Could not be detarmined | 28e. Pleca of injury building, atc. | y - At home, fe | ırm, stre | et, fectory, office | - | 28f. Locati | on (Street and Num Town, State) | ber or Rure | I Route Number, |
| Ö | rs after all Dir | Cer | - I Homodo | bulloning, atc. | (Зреспу) | | | | Oily or | rown, olaley | | |
| | To the Hospital or Attending Physician: The I within 24 hours after dash. To the Fureral Director: After this certificate he completely filled in by the funeral director, page | edical | 29a. Certifier Certifying Physic (Check only 2 Medicat Examine | er: On the basis of e | xaminetion en | dor Inve | occurred at the ti | ime, dete en opinion, dee | d pieca, and due to th occurred at the ti | the cause(s) and m | snner es st , and due to | ated. the cause(s) |
| | thin 2 the mple | Med | 29b. Signeture and title of certifier | end menner stete | ed. | | 29c. Licen | se number | | 29d. Dete sign | ed (Month . | Dev Year) |
| - | 5 ¥ 5 8 | | Nath | MI | | | 200. 2.00. | | 689 | _ | | |
| | | | 30. Name and address of person who com | ministed source of de- | th /item 03-1 | (Tune 17 | zint) | | | 3111931 | 11116 | 27TH 1996 |
| | | | JAMES APPIAH-PIP | | NOR | TH A | RUNDEL | 1920H - | TAL301 1 | HOSPITALD | PRIVE F | BALTO MD 2166 |
| | Sta | te | 31. Dete filed (Month, Dey, Year) | 32. Registrer | s Signeture | | | | 1 | | | |
| | Registr | ar | JAN 30 199 | 6 | Property of | Cal | 11. | | 11 | | | |
| | The second second | | | | | | e all | | | | | |

32. Registrer's Signature

Automotive and the second of t

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| DALL INCOLO, MANICAND 21213-0020 Nor death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | al examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|--|--|--|---|
| TO THE HISPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing shours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the item and manual physician and completely filled in by the item at the completely filled in by the c | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

27. MANNER OF DEATH

5 Pending

8 Could not be

detarmined

1 X Natural

2 Accident

3 Suicide

4 Homicide

96 03824 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARGARET ANN REYNOLDS JAN. 996 6:00 A 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR DAYS HOURS 235-46-2841 1 M 2 X F YRS. Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR CUMBERLAND NURSING HOME CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY CUMBERLAND 1 X YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 212 SARATOGA STREET 21502 U.S.A 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Ricen, etc.)

1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 12 BEAUTICIAN HAIRDRESSING 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumama ALEXANDER GILLIS ROSE BECKNER 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY DUMAS 214 SARATOGA STREET-CUMBERLAND, MD 21502 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE CUMBERLAND CREMATORY CUMBERLAND. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Kende GEORGE-UPCHURCH FUNERAL HOME, 202 GREENE ST., CUMBERLAND, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart feilure. List only one cause on each line. **IMMEDIATE CAUSE (Final Onset and Death** disease or condition resulting in death) CORONARY ARTERY DISEASE 10 Years Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 X NO OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN [

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 TES 2 1 NO

1 Inpatient 2 ER/Outpatient 3 DOA 28e. DATE OF INJURY (Month, Day, Year)

OTHER:
4 M Nursing Home 5 Residence 8 Other (Specify)

D33280

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stelle)

29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner se stated.

2 ___ MEDICAL_EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner ea stated.

29b. SIGNATURE AND TITLE OF CENTIF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.-Johnson Hghts.Med.Bldg.-Kent Ave.-Cumberland, MD Sunil Gupta,

32. REGISTRAR'S SIGNATURE

Jan.27,1996

21502

X

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BEAUTICIAN

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HAIRDE

ROSE BECKNER

ALEXANDER GILLIS

214 SARATOGA STREET-CUMBERLA

MARY DUMAS

CUMBERLAND CREMATORY 1/27/18 CUMI

GEORGE-UPCHURCH FUNERA 202 GREENE ST., CUMBERL Mondy A. Upduch

CORONARY ARTERY DISEASE

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

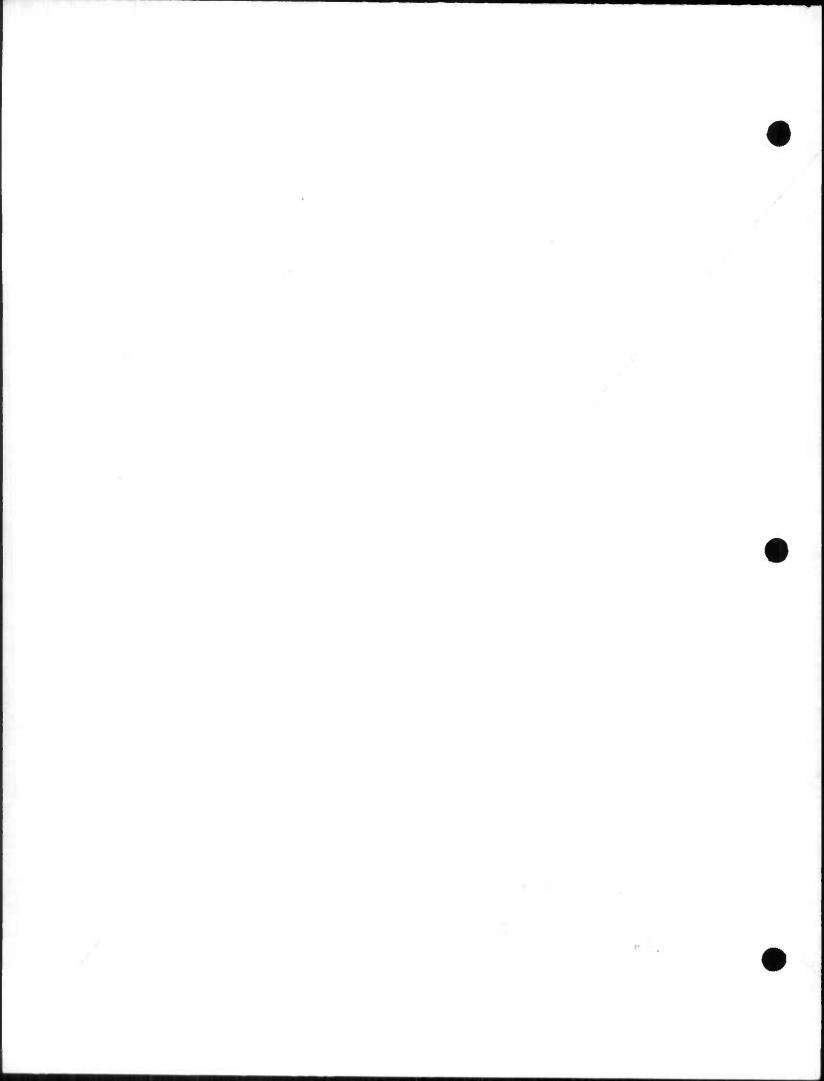
TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MADVIAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

| 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | / DEPARTM | | HEALTH AND I | WENTAL HYGI | | | |
|--|---|--|-------------------------|---|------------------------|--------------------|---|--------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | OLITIN 107 | AIL OI | DEATT | 2. DATE OF DEATH | | 3. TIME OF DEAT | н |
| | aboth Ra | 0.0 | | | MONTH | 5, 199 | EAR | О м |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. | last birthday) IF | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. | BIRTHPLACE (State or For | reign |
| 212-24-0182 | 10 M 2 XF 68 | YRS. MON | ITHS DAYS | HOURS MIN. | (Month, Day, Year | | country) Jest Virgi | ind- |
| 9a. FACILITY NAME (If not institution, give | | | CITY, TOWN | OR LOCATION OF DE | | 9c. COUNTY | | 1119 |
| | 1 | | | , | | 10 | 1/ | |
| ST. VINCENT | de Paul Col | NIEF | 1 10 | stbur | 9 | 171 | legary | |
| 10a. STATE 10b. COUNT | 1 | | OWN OR LOCA | | | | 10d. INSIDE CITY | |
| ohio c | lark | 5/ | orIN. | g Field | | | 1 X YES 2 | NO |
| 10e. STREET AND NUMBER | | | 10 | of. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| 2819 Rod C | Joach Drive | ٥ | | 4550 | 5 | 4 | 1514 | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 | | | CENDENT OF HISPAN pecify Cuben, Maxica | | | RACE — American India Black, White, atc. | in, |
| 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DATES | Ano | | S 2 NO Specify | | | Specific: | |
| | | | | | | | white | 3 |
| 16. DECEDENT'S EDI (Specify only highest grad | | (Give kind of work the Do NOT use ret | done during m | | 16b. KIND OF | BUSINESS/INDUS | TRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | | DOT | | nedic | -/ | |
| 17. FATHER'S NAME (First, Middle, Lest) | | FINA | awce | Dept, | ME (First, Middle, Mai | | 01 | |
| | 1/2010 | | | Car management and | | | | |
| 19a, INFORMANT'S NAME (Type/Print) | athermon | | | De | prothy | bere | 00) 21532 | |
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| Kenweth E. | 77 | | | Terra | ce FI | 051 100 | ra. Md. | |
| 1 X Buriel 2 Cremetion 3 Res | moval from State 20b. PLAC | ceand date of di cremetory or other | ISPOSITION (F place) | vame of | DATE 200 | LOCATION - City | or Town, Stata | 1 |
| 4 Donation 6 Other (Specify) | | SP[MI | | Pank AND ADDRESS OF FA | CILITY | UMBER | 1000, 1110 | 7, |
| | | | Leas | sure-57 | ein, In | c, 230 | Baltin | ore |
| cinet o | a. Relay. fr | 1, | | | | 4 | , 21502 | |
| 23. PART I. Entar the diseases, or | | | | | | | . Approxima | ata |
| IMMEDIATE CAUSE (Final | . List only one ceuse on each I | iine. | | | | | Onaat snd | |
| disease or condition resulting in death) | Meta | state | ren | l carre | nome | | 1140 | n. |
| Teaching in deadily | DUE TO (OR AS A CON | SEQUENCE OF): | | | | | 1 | |
| | b | | | | | | | |
| Sequentially list conditions, if sny, leading to immediate | DUE TO (OR AS A CON | ISEOUENCE OF): | | | | | | |
| CAUSE (Disease or injury | c | | | | | | | |
| that initiated events resulting in death) LAST | | | | | | | | |
| resulting in destin) EX37 | d | | | | | | | |
| PART II. Other algnificant condition | one contributing to deeth but no | ot resulting in t | he underlyl | ng cause given in | | AN AUTOPSY | 24b. WERE AUTOPSY FI | |
| arteria | selevin, | | | | | FORMED? | AVAILABLE PRIOR COMPLETION OF C | |
| | | | | | 1 76 | S 2 KNO | OF DEATH? | NO. |
| DID TOBACCO USE CON | TRIBLITE TO CALISE OF D | FATH YES | | Z UNCERTAI | ND | | 1 YES 2 | .0 |
| 25. WAS CASE REFERRED TO MEDICAL | | LACE OF DEATH (| | | | | | |
| EXAMINER? | HOSPITAL: | _ 0 | THER: | | A C Other (Passife) | | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME O | F 28c, IF | me 5 Realdence | 28d. DESCRIBE HO | OW INJURY OCCUP | RED | |
| 1 Natural 5 Pending | (Month, Day, Year) | INJURY | | YORK? | | | | |
| 2 Accident Investigation 3 Suicide & Could not be | 28a, PLACE OF INJURY - A | it home, farm, stree | | | 281. LOCATION (St | reet and Number or | Rural Route Number, | |
| 4 Homicide B Could not be | building, atc. (Specify) | | | | City or Town, S | (teto) | | |
| 29a, CERTIFIER | Augus 4 (20) (20) (20) | Learning to the second | | | | | | - |
| (Check only 1 CERTIFYING PHY | SICIAN: To the best of my knowledge NER: On the besis of exemination and | | | | . , | | | dated. |
| 296. SIGNATURE AND TITLE OF CERTIF | ER | | | 29c. LICENSE NU | MBER | 29d. DATE S | IGNED (Month, Day, Year) | |
| Hem ! | Sur MD | | | D1253 | 2 | ▶ i/. | 19/96 | |
| 30. NAME AND ADDRESS OF PERSON W | | | | | | | 2150 | 3 2 |
| George M. 1 | Breza, M.D | | Set | on Dr. | comb | erlan | d. md. | |
| JAN 2 9 1996 | Japa Bauslen-Ren | | | | | | | |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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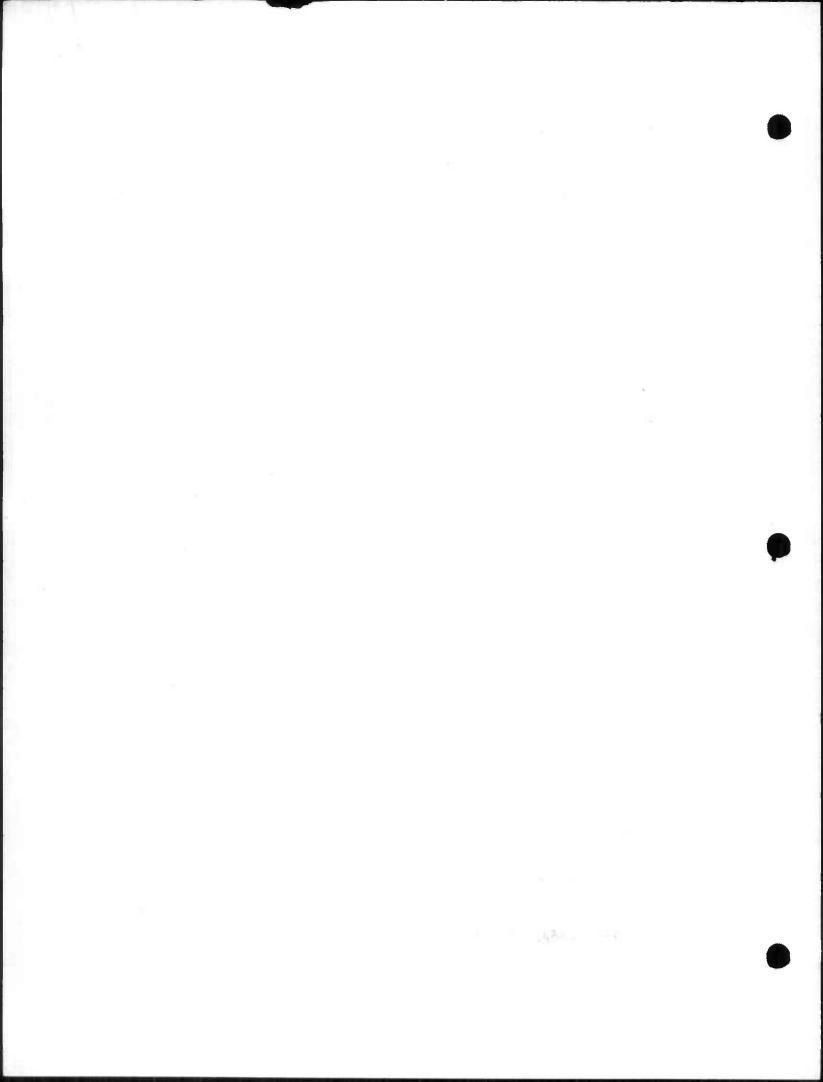
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| AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. | |
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| IING | After | 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| LEND | OR: J | ther c |
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| est. | 7 | 54 |

| | | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH CERTIFICATE OF DEA | | |
|--|---------------|---|--|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH | DAY YEAR 3. TIME OF DEATH |
| | | ALBERT THEODORE ROCKWELL | | 11:45 A M |
| P | | 705-10-8712 1- M 2 - F 87 YRS. MONTHS DAYS HOURS | Sep 28. | 1908 MD |
| shou | | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCAT | | 9c. COUNTY OF DEATH |
| 5, | СТОВ | SACRED HEART HOSPITAL CUMBERLAN | D | ALLEGANY |
| . Pages 1 | DIREC | MD Allegany Cumberland | | tod, INSIDE CITY LIMITS? Ny∏ YES 2 ☐ NO |
| permi | | 10e. STREET AND NUMBER 101. ZIP COL | DE | 10g. CITIZEN OF WHAT COUNTRY? |
| n. ansit | ᄪ | 134 New Hampshire Avenue 215 | 02 | USA |
| -AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit permit. Pages 1, 2, 3 should once. | BY FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT | OF HISPANIC ORIGIN? (Specify Yearn, Maxican, Puerio Rican, etc.) Specify: | ee or No— 14. RACE — American Indian, Black, White, etc. Specify: White |
| YLAND 21215. by the hospital or attend be detached for use as at once. | ETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5 +) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of work life. Do NOT use retired.) | 16b. KIND OF BU | USINESS/INDUSTRY |
| Spita Shed 1 | AP. | 12 Former Employee | Rail | lroad |
| AN the hos detach | COMPL | | THER'S NAME (First, Middle, Maider | |
| RYL ed by a | BE | Edward Rockwell | Emma (Brubake: | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | ٩ | Blanche C. Rockwell 19b. MAILING ADDRESS (Street and Number) 19d. MAILING ADDRESS (Street and Number) 134 New Hampshire | | |
| | | 29s. METHOD OF DISPOSITION 29s. METHOD OF DISPOSITION 3 □ Removel from State cemetery, crematory or other place) | | OCATION — City or Town, State |
| IMORE Page 6 may al director, pa | | 13 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) Abe Cemetery | | Short Gap, WV |
| ALTIMORE, death. Page 6 may be tuneral director, page tuneral director, page | | 21. SIONATURE OF EUNERAL SERVICE LICENSEE / 22. NAME AND ADDR | li Funeral Hom | |
| | | Campel: Cumberli | | |
| BA hours after d d in by the or removal. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of di | | piretory srreat, Approximata |
| within 24 h mpletely fille cremation, | | ahock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): | wary tile | inferval Between Onaat and Daath 2 12 y |
| BOX 68: cate be execute physician and co prior to bunia er traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events b. DUE TO (OR AS A CONSEQUENCE OF): | U | |
| P.O. E th certifica tending phy al Hygiene or other | FE | reaulting in death) LAST | | |
| RECORDS, P w requires that the death is been signed by the atter pt. of Health and Mental I 3 shows any injury, o | MEDICAL CE | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause | | ORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| REC requir een s of H | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 💆 UN | CERTAIN | 1 TYES 2 NO |
| 2 H an | AN | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | CERIAIN LI | |
| F VITAL SICIAN: The lan certificate has the State Dep | SIC | EXAMINER? | Residence 6 Other (Specify) | |
| O FF sits | Y PHYSICIAN: | 27. MANNER OF DEATH | 26d. DESCRIBE HOW | INJURY OCCURED |
| DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is man | тер ву | 2 Accident investigation 3 Suicide 6 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, straet, fectory, office building, atc. (Specify) | 28f. LOCATION (Street City or Town, State | t and Number or Rural Route Number, e) |
| OR OR DIRE | COMPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axaminstion and/or investigation, in my optnion, death occurred. | | |
| TO THE HOSPITAL TO THE FUNERAL DE filed within 72 P IMPORTANT: If i | TO BE C | 29c. LI | CENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) JANUARY 25,1896 |
| PLS ! | Ě | Robert Orlino, M.D. 902 Seton Drive C | imberland ! | MD 21502 |
| | | 31. DATE FILED (MOTAN 2") 9 1996 32. REASTRANGE SIGNATURE SALES | · | |



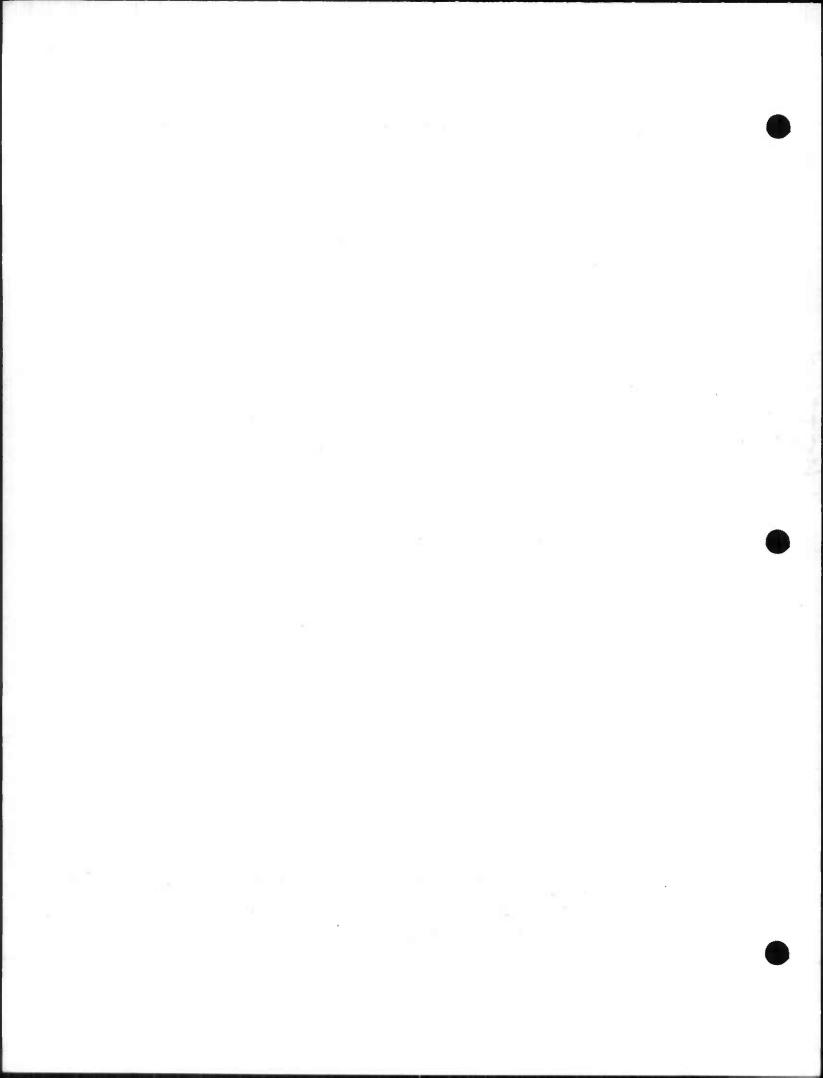
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE

| | * REGISTRAR CERTIFICATE OF DEATH REG. NO. | |
|---------------|--|----|
| | 1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATN | |
| Ì | MICHAEL JUDE ROMIG JANUARY 22,1996 4:17 P. | М |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign | |
| | 215-38-3478 1 M M 2 D F 54 YRS. MONTHS DAYS HOURS MIN. MAR. 6, 1941 CALIFORNIA | |
| | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | |
| Œ | 2602 MUSKOGEE STREET ADELPHI PRINCE GEORGE'S | |
| DIRECTOR | 2602 MUSKOGEE STREET ADELPHI PRINCE GEORGE'S |) |
| ĕ | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? | |
| 5 | MARYLAND PRINCE GEORGE'S ADELPHI | |
| 7 | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? | |
| E. | 2602 MUSKOGEE STREET 20783 U.S.A. | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yea or No. — 14. RACE — American Indian. | _ |
| | IF YES, DIVE WAR OR DATES 1 YES, 2 KI NO Specify: Specify: | |
| BY | 3 Wildowed 4 Divorced WHITE | |
| | 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | |
| E | (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.) | |
| 립 | 5+ ATTORNEY/LOBBYIST LEGISLATION | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) | |
| | WILLIAM FRANCIS ROMIG TERESA REGNERY | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | |
| 2 | JOAN BEARD ROMIG 2602 MUSKOGEE STREET-ADELPHI, MD 20783 | |
| | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State | |
| | 1 X Burlisi 2 Cremation 3 Removal from State cametery, crematory or other piece) 4 Donation 5 Other (Specify) ADELPHI, MD | |
| | 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | |
| | UPCHURCH FUNERAL HOME, P.A. | |
| | 202 GREENE ST., CUMBERLAND, MD 2150 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, Approximate |)2 |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in deeth) a. ANAPLASTIC EPENDYMOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | |
| ERTI | that initiated events resulting in desth) LAST d | |
| MEDICAL C | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDIN AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO M UNCERTAIN | |
| M | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | |
| Sic | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | |
| PHYSICIAN: | 27. MANNER OF DEATN 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED | |
| | 1 Naturel 5 Pending (Month, Day, Year) INJURY WORK? M 1 YES 2 NO | |
| BY | 2 Accident Investigation 28a. PLACE OF INJURY — At home farm street factory office. 28l. LOCATION (Street and Number or Burel Paule Number) | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined 288. Could not be building, atc. (Specify) | |
| COMPLET | AA APPENDIA | |
| PL | 29s. CERTIFIER (Check only) CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | |
| O | One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated | d. |
| | 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) | |
| BE | Morrell C. Seennam 10 D09799 1-24-96 | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PEATH (ITEM 27) (Type, Print) MANULL C. QUINNAME | |
| | 11120 New Hampshike HVE SIVER Spring MI | 0 |
| | 31. DATE FILED (Month, Day, 1607) 32 REGISTRAN'S SIGNATURE 2070 | 4 |

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending phy | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the but he find writin 72 hours after death with the State Dest of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - FOR STATE OF REGISTRAR | MARYLAND / DEPARTI CERTIFIC | | | REG. NO. | | |
|---------------|---|--|--|--|---|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Sulit 19 | Railey | , | Mo | TE OF DEATH DAY | 6 9L | 3. TIME OF DEATH 728PM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 214-42-8936 9a. FACILITY NAME (If not institution, give street and number) | 52 YRS. MC | UNDER 1 YEAR DAYS DAYS D. CITY, TOWN C | | | Cou | THPLAGE (State or Foreign aryland DEATH |
| TOR | Andrews Air Force Base H | ospital | Camp | Spring | | Prince | George |
| L DIRECTOR | 10a. STATE 10b. COUNTY Maryland Prince Geory 10b. STREET AND NUMBER | 10c. CITY, 1 | own or locat | e | | | 10d, INSIDE CITY LIMITS? 1- YES 2 NO |
| FUNERAL | 3727 Monacco Court | | 101 | 20747 | | USA | WHAT COUNTRY? |
| BY FUN | 1V Never Married 2 Married FORCES? | NT EVER IN U.S. ARMED I YES 2 NO WAR OR DATES A | If yes, sp | ENDENT OF HISPANIC ORI ecity Cuban, Mexican, Puar 2 NO Specify | | Bi | CE — American Indian, sck, White, stc. |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 | +) Laborer | k done during mo stired.) | | Complete | | |
| OMP | 17. FATHER'S NAME (First, Middle, Last) | Laborer | | 18. MOTHER'S NAME (Fin | Campbell | | inc. |
| BE C | Unknown | | | Virginia I | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) Terri L. Railey | | | nd Number or Rural Route N | | | 20747 |
| | 204. METHOD OF DISPOSITION | 20b, PLACE AND DATE OF | DISPOSITION (No | Court, For | ATE 20c. LOCATI | | |
| | 1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | cemetery, crematory or other | eld Cer | netery 1 | The second second | - | ville, Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | ٩ | | nie Smith F Box 1687, | | | 601 |
| | | at caused the death. Do not use on each line. A A LANDING () (OR AS A CONSEQUENCE OF): | | | | | Approximeta Interval Between Onset and Death |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | O (OR AS A CONSEQUENCE OF): | | | | | |
| MEDICAL C | PART II. Other significant conditions contributing to | death but not resulting in | the underlyIn | g cause given in Part I. | 24e. WAS AN AUT PERFORMED 1 YES 2 |)? | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | DID TOBACCO USE CONTRIBUTE TO CA | AUSE OF DEATH YES | | UNCERTAIN 🗷 | | | 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE DEFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26 PLACE OF DEATH | (Check only one) | | | | |
| 14Si | | ER/Outpatient 3 DOA 4 | ☐ Nursing Horr | e 5 🗆 Rasidenca 8 🗆 O | Ther (Specify) DESCRIBE HOW INJUI | BY OCCUBED | |
| | 1 Natural 5 Pending (Month, | Day, Year) INJUR | Y WC | PRK? | DESCRIBE HOW MOO | NY COCCILED | |
| TED BY | 3 Sulcida 28a. PLACE | OF INJURY — At home, farm, stre , etc. (Specify) | et, factory, offic | | OCATION (Street and I City or Town, State) | Number or Run | al Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of MEDICAL EXAMINER: On the best of | | | | | | e(s) and menner se stated. |
| TO BE C | 290. SIGNATURE AND TITLE OF CENTIFIER STANDARD AND ADDRESS OF PERSON WAS COMPLETED ON | fige of Death (ITEM 27) (Your Pr | 8 | 121230 | 1 | M. DATE SIGN | eg 27, 1992 |
| | ALGUSTO P. Rodo 1 States 31. DATE FILED (MOVIN, Day, Mar) 32. SINGEST | AN SIGNATURE SAND | 0091 | oy hum (| 01.43 | N, Y | 10 20748 |



REG. NO.

FOR STATE REGISTRAR

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| DIVISION OF VITAL | ATTENDING P |
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR BILLY W. RUARK HARK TANUARY 996 1351 М 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Jan. 25, 5 SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS Md. 218-16-8861 1X M 2 F 73 1922 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? De. Sussex Delmar 1 TYES 2 X NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE Rt.#2 Box 217A 19940 USA use as the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexicen, Puerto Rican, atc.)

1 □ YES 2 □ NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried Specify: White ВУ 3 Widowed 4 Divorced ED 15. DECEDENT'S EOUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe H completely filled in by the funeral director, page 5 should be detached for trial, cremation, or removal. Elementary/Secondery (0-12) College (1-4 or 5+) COMPL Q Truck Driver Newspaper at once. 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme) Avery Ruark Sarah Owens Hastings notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Rt.#2 Box 217A Delmar, De. 19940 Irma L. Ruark 90 20s. METHOD OF DISPOSITION
1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Springhill Memory Gardens 1-26 Hebron, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc. William 13 E. Grove St. Delmar, De. 19940 23. PART i. Enter the disesses, or complications that cause the dasth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or haart failure. List only one cause on each line. medical Approximata Interval Between **Onset and Death** IMMEDIATE CAUSE (Final the disease or condition reaulting in death) other traumatic event, DUE TO OR AS A CONSEQUENCE OF - and Value Togle burial. CERTIFICATION and Sequantially list conditions, CONSEQUENCE OF) prior to if any, leading to immediate the attending physician i Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO OR AS A CONSEQUENCE OF that initiated events resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL signed by t Health and AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO certificate has been the State Dept. of 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one Hem EXAMINER? HOSPITAL OTHER: 1 | Inpetient 2 | ENfoutpetient 3 | DOA 10 with the 26e. DATE OF INJURY (Month, Day, Year) 27. MANNED OF DEATH 284 DESCRIBE HOW INJURY OCCURED 26b. TIME OF 28c. INJURY AT WORK? marked, this INJURY € Natural 5 Pending Investigation TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death w IMPORTANT: If Item 28 is marke м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Sulcide 28f, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homlelde 29e. CERTIFIER 1 📝 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h SIGNATURE AND TITLE OF CERTIFIER 29c. LIPENSE NUMBER 002020 BE 2 DDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) reca (NK) 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE JAN 24 1996 Jalia Davidson Randall 6

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygier Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day **Physician** THELMA BEATRICE RHOTEN 29, 1996 JAN. 1:30 PM. /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1258 OLD MANCHESTER RD. WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** 1□M 2⊠F 219-14-9492 Yrs. 88 Director NOV. 24, 1907 MARYLAND Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD. CARROLL WESTMINSTER 10e. Street and Number 10f. ZIp Code 10g. Citizen of What Country? 1258 OLD MANCHESTER RD. permit. Pages 1 and 2 should be flied within 72 hours effer death v Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a any injury or other tranmatic event, the Mental 21157 USA. Funerai 14. Reca - American Indian, 12. Wes Decedent Ever in U,S. 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Armed Forces?
1 ☐ Yas 2 ☐ No
If Yes, Give Bleck, White, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced If Ye*s*, Give Year or Dates: Completed 16a. Decedent'a Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSE WIFE HOME MAKING 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Be VIVIAN DAVIDSON JESSIE McCULLOUGH 2 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 1 1 5 7 19a. Intormant'a Name/Raletionship (Type, Print) JOANN RHOTEN -DAUGHTER 1258 OLD MANCHESTER RD., WESTMINSTER, MD. 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State XIXBuriel 2 Cremation 3 Remove trom State 2/1/96 WESLEY CEMETERY HAMPSTEAD, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility FLETCHER FUNERAL HOME 254 E. Main St. WESTMINSTER, MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each lina. Physician /Medical Obstructive JAWNDICP Immediate Causa (Final disease or condition resulting in death) Examiner consequence of): Tumor Porta Hepatis Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tunnerel director, page 2 should be detached for use as the buriel-transit completely filled in by the tunnerel director, page 2 should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Box 68760. Physician/Medical Due to (or as a consequenca of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PRITENSION by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Waa an autopsy performed? Completed 1 Yes 2 DIN 1 □ Yes 2 □ No 25. Was case retarrad to medical Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 🗷 Rasidenca 6 ☐ Other (Specify) Certification: To 1 Yes 2 Ne 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and mannar as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartities D02386

State Registrar

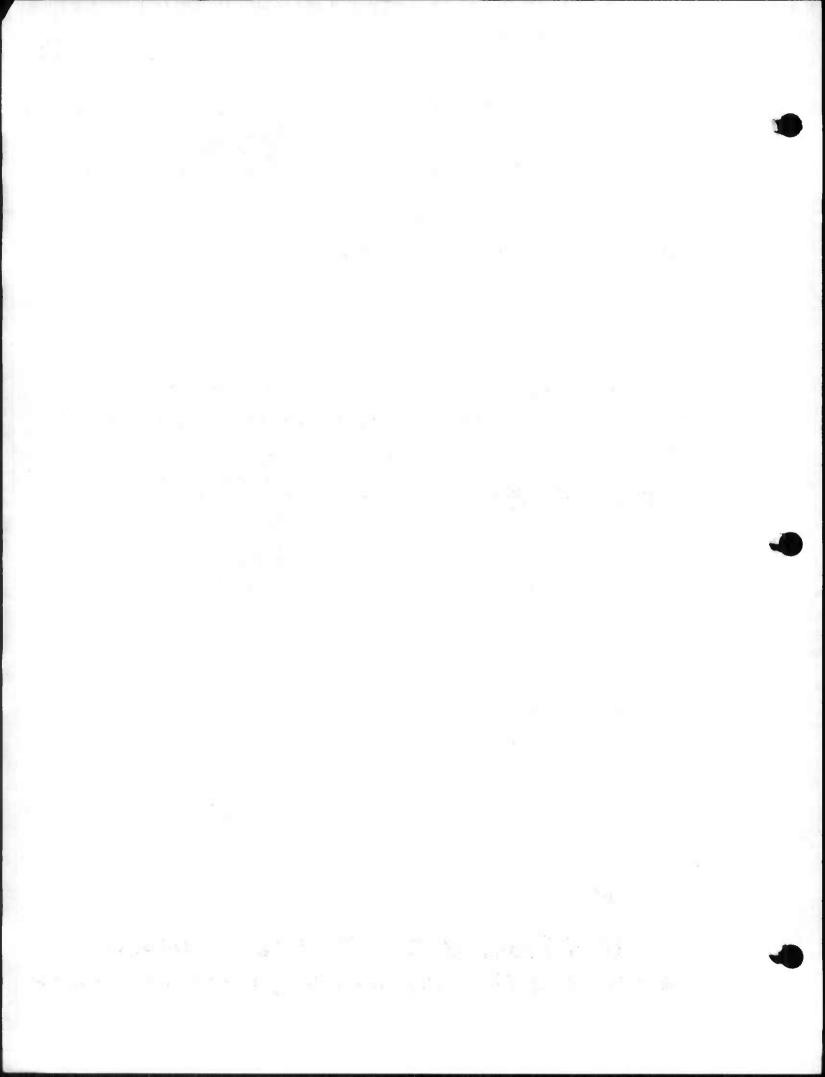
31. Date tlied (Month, Dey, Year,

011

30. Name end addrass of person who complated causa of daath (Itam 23a) (Type, Print)



MAIN St MANChester Md 21102



3. TIME OF DEATH

7:30 P.

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

tX YES 2 □ NO

20007

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Onset and Death

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24b. WERE AUTOPSY FINDINGS

1 - YES 2 - NO

AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

8. BIRTHPLACE (State or Foreign

New York

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

Specify:

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Pages 1, 2, 3 should

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| L OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by | . DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should t | |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 24,1996 Helen January Manning Ray A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. (Month, Day, Year) Jan. 20, 1903 HOURS 216-44-4246 1 M 2 V F 93 YRS 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Manor Care Potomac Potomac RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION Maryland Montgomery Rockville 10e. STREET AND NUMBER 101. ZIP CODE 10834 Brewer House Road 20852 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 TYES 2 NO Specify: 3 X Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 4 administrative ass't. I.R.S. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Edward Reynaud Eugenie Hawxhurst 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugenie Ridgway 10834 Brewer House Rd., Rockville, Md. 20852 20s. METHOD OF DISPOSITION

↑ Burlel 2 □ Cremation 3 □ Ramoval Irom State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE Gate of Heaven Cemetery Jan.27,96 Silver Spring, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF PAINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 2222 Wisconsin Ave. N.W. Wash. DC 23. PART Lenter tha diseases, or complications that caused tha death. Do not anter the mode of dying, such as cardisc or respiratory arrest, ahock, or haart fallure. List only one cause on each ilne. IMMEDIATE CAUSE (Final huesiple disease or condition_ reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): enclos Vest. Disease Le us Clesque Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate exercios elero Vie cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events weralised resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 1 - YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4

Nursing Home 5 □ Rasidenca 6 □ Other (Specify, 1 YES 2 NO 1 Inpetient 2 I ER/Outpetient 3 I DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED

26a. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) a Could not be 4 Homicide determined CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated, (Check only one)

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

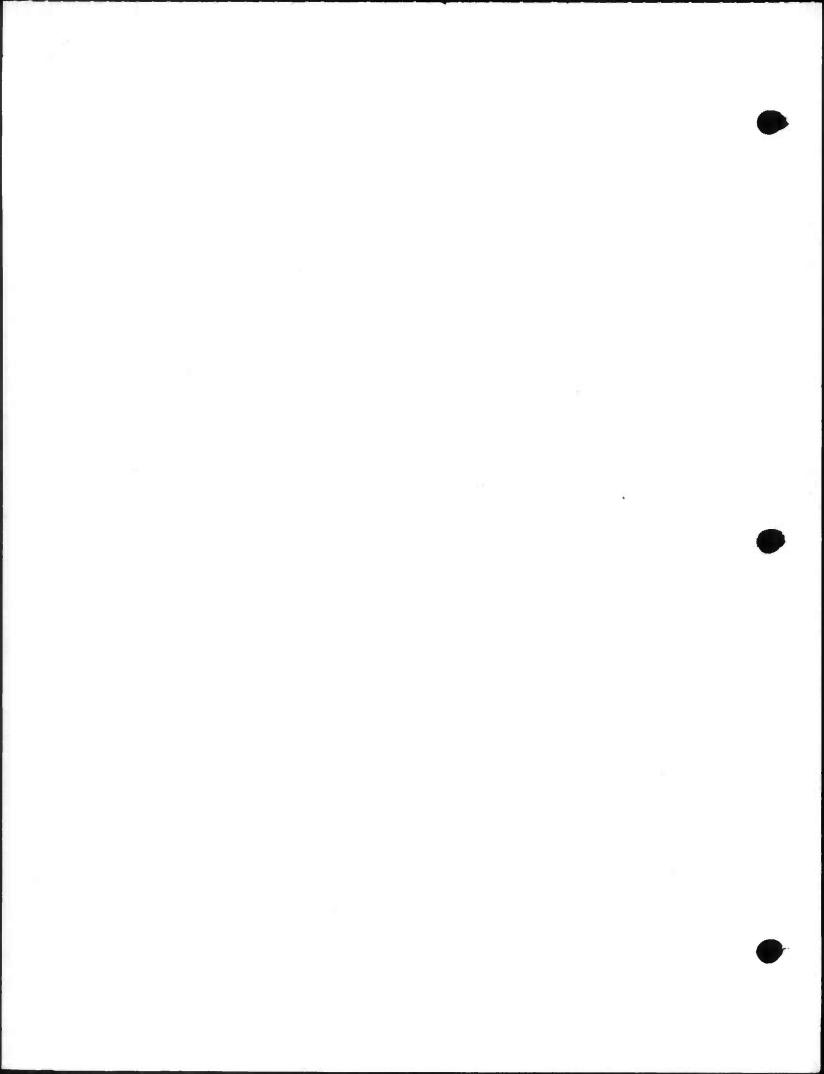
| 96. SIGNATURE AND TITLE OF CERTIFIER CILLEST 1 | 29c. LICENSE NUMBER D 254/0 | 29d. DATE SIGNED (Month, Day, Year) |
|---|-----------------------------|-------------------------------------|

1 YES 2 NO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH HEM 27) (Type, Print)
380/WIEKNAHORRE JKWE Silver

32 AGGISTRAR'S SIGNATURO 1 3 0 1996

Pending Investigation



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 96 03832

| | | | | | ary raine / L | | icate of | Death | | g. No. | U | 00002 | | |
|---------------------------------|---|----------------|--|----------------------------------|---|---|----------------------------|--|----------------------------------|------------------|------------|---|--|--|
| | | | 1. Decedent's Neme (First, Middle, La | st) | | | | | 2. Dete of Deetl Month | h | Yeer | 3. Time of Death | | |
| | Physici /Medio | | Frances Riley | -Dayton | | | | | February | р Dey у 1 19 | 96 | 4:00 AM | | |
| | Examir | | 4e. Facility Neme (If not institution, give | re street end number) | | | | 4b. City, Town, or L | ocation of Deeth | 4c. County | of Deeth | | | |
| | | | Spring Brook Nur | sing Home | | | | Silver Sp | | | ntgon | | | |
| | Funeral | | 5. Social Security Number 6. S | | e (In yrs. lest bir | Mo | Under 1 Year onths Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Birth (Month, Day, | Year) | 9. Birthp | elece (State or Foreign | | |
| | Director | | 220-40-9132 | I□M 2∏F | 90 | Yrs. | | | Dec. 6, | 1905 | | sa, KY | | |
| | pue * | | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. City, Tow | n or Locatio | on . | | | | 1 | 0d. Inside City Limits | | |
| | Aanyl aho | ៦ | | | Asht | | | | | | | 1 Yes 2 No | | |
| | the the | Director | Maryland Montg 10e. Street and Number | omery | ASIIL | | Of. Zlp Code | | 10 | Og. Citizen of V | Vhat Cour | ntry? | | |
| | With or | ō | 209 Ashlawn Drive | | | | | 861 | | | SA | , | | |
| | Seath Fe 2: | era | 11. Meritel Stetus | 12. Wes Decedent I | Ever In U,S. | 13. Wes | | Hispenic Origin? (Spoan, Mexican, Puerto | pecify Yes or No- | | | ean Indian, | | |
| 0 | s 1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mentel Hygiena. If Health and Mentel Hygiena. The marked other than "natural", or Itema 23a or 28a-f ahow other traumatic evant, the Medical Examiner must be notified at other traumatic evant, the Medical Examiner must be notified at | Funeral | 1 Never Merried 2 Merried | Armed Forces? 1 ☐ Yes 2 ☒ î | lo | | | | Ricen, etc.) | | k, White, | | | |
| 8 | al', o | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Yeer or Detes: | | 10 | Yes 212 No | Specify: | | Specify | . Whi | re | | |
| 2-0 | 72 ho | Completed | 15. Decedent's E | | 16a. | Decedent's | s Usuei Occu | petion | kina | 16b. Kind of Bu | usiness/in | dustry | | |
| 7 | ithin en | npie | Elementery/Secondery (0-12) | College (1-4or 5 | +) | life. DO N | VOT use retire | during most of work ad) | 9 | | | | | |
| 7 | Hygier Hygier Wher th | ပိ | 12 | | | House | wife | Linusarius | | Own Hor | | | | |
| Maryland 21215-0020 | od at H of H | Be | 17. Father's Neme (First, Middle, Last | | | | | | ne (First, Middle, M | | 10) | | | |
| Ž | 2 should and Men is marks | T _o | Robert Peyton Rob | | 101 | | | | Belle Abb | | 0 | 0.44 | | |
| M | 12 sh h and h and r le m traum | | 19e. Informent's Neme/Reletionship (Charles E. Riley | Type, Print) | | _ | | tend Number or Ru Prive, Ash | | 20861 | Stere, ZI | (Code) | | |
| ď. | Healt Healt Healt ther | | 20e. Method of Disposition | | | | | | | 20c. Location - | City or To | own. State | | |
| ٥ | it of | | 1 ☐xBurlel 2 ☐ Cremetion 3 ☐ | | 20b. Piece of camete. | | | | | | | | | |
| Baltimore, | it. Parturut rtant njury | | 4 Donetion 5 Other (Special Service Lical | | Cedar | | | ery 2/ ess of Facility | 2/96 S | uitlan | d, MI |) | | |
| Ba | permit. Pages 1 and 2 s Department of Health ar Important: if frem 27 is any injury or other trau | | 21. Sonature di Funerei Service Licai | | | | | Collins | Funeral | Home, | Inc. | | | |
| | | | Cindrew | Lole | 4 - 4 - 4 - 5 | 500 | Univer | sity Blvd | I.W., Sil | ver Sp | ring, | MD 20901 Approximate | | |
| į, | | , | 23a. Part T. Enter the disease, or commiscations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only the cause on each line. Approximately a such as cardiac or respiratory arrest, interpretation of the cause of th | | | | | | | | | | | |
| | Physician /Medical | | Immediate Cause (Final | | | | | | | | | | | |
| | Examiner | | diseese or condition resulting in deeth) | 0, | ple Str | | | | | | | Years | | |
| | _0.00 | ē | | | Due to (or as a | | ce of): | | | | | 10 ** | | |
| | ificata be executed g physician and as the burial-transit | Examiner | Conventielly list conditions | U. | tension | | ce of): | | | | | 10 Years | | |
| o | ificata be executed g physician and as the burial-transit | EXS | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | 200 10 (01 00 0 | 001100400111 | 55 5.7. | | | | | | | |
| 68760, | ta be ysicie | edicai | Ceuse (Diseese or Injury thet initieted events resulting in death) Lest | c | Due to (or es e | consequenc | ce of): | | | | | | | |
| | | - | resolding in deadily Lest | | | | | | | | 1 | | | |
| Box | The law requires that the death cert ite has been signed by the attendin paga 2 should be detached for use | Physiclan/N | | d | | | | | | | | | | |
| E | he at he at hed fo | sici | Pert II. Other significant conditions of | contributing to death b | ut not resulting le | n the under | tyling cause g | Iven in Pert I. | 23b. Dld to | bacco use co | ntribute t | o the cause of death? | | |
| <u>.</u> | at the | Phy | | | | | | | t _P Y | 88 2 No | 3 Pro | bably 4 Unknows | | |
| ဟ် | the digner | by | | | | | | | | | 0.00 | | | |
| 0 | w require been si should I | Completed | | | | | | | 24a. Was a perform | | av | ere sutopsy findings reileble prior to empletion of cause | | |
| ဝ | law lasb a 2 s | nple | | | | | | | | | | death? | | |
| <u></u> | The pag | S | | | | | | | 1 □ Ye | s 2 No | 11 | ☐ Yes 2☐ No | | |
| | Physician: The this certificate iral director, pag | Be | 25. Was case referred to medical examiner? | Hospitel: | | | 0 | | th (Check only on | e) | | | | |
| 0 | physic this c | To . | 1 ☐ Yes 2 ☒ No 27. Menner of Death | 1 LI Inpatie | | | SLI DOA | 48 | ome 5 Reside | | | (y) | | |
| 2 | Iling F | lon | 1 Neturel 5 ☐ Pending | 28a. Dete of Inju (Month, Day | Year) 200. | Time of njury | 28c. Inju Wo M 1 | ork? ☐Yes 2☐No | 20d. Describe no | W Injury occur | 160 | | | |
| Division of Vital Records, P.O. | Attending at death. ector: Aftai by the fune | ical | 2 Accident investigation 3 Suicide 6 Could not be | O O Diese of Ini | inc - At home fe | | | | 28f. Location (St | reet end Numi | per or Rur | al Route Number, | | |
| <u>\</u> | or Attending of the clear death. Director: After in by the fune. | Certification: | 4 ☐ Homicide determined | building, etc | . (Specify) | ,, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | lootory, omoo | | City or Town | | | | | |
| | Hospital 24 hours Funeral ataly filled | | 29e. Certifier 1 TXCertifying Pf | nysician: To the best of | of my knowledge | deeth occ | curred et the t | ime, dete end plece | , end due to the ca | ause(s) end ma | anner 86 s | stated. | | |
| | 24 h | Medical | (Check only 2 Medical Example) | minar: On the basis of | examinetion en | d/or Investi | getion, In my | opinion, deeth occu | rred at the time, d | ete end place, | and due t | o the cause(s) | | |
| | To the Hospital or Attanding Physician: The law within 24 hours effer death. To the Funeral Director: Attar this certificate has completely filled in by the funeral director, page 2 | Me | 29b. Signature and title of certifier | . 111111 | | | 29c. Licen | nse number | 2 | 9d. Dete signe | d (Month, | Day, Year) | | |
| | | | MILLIN | M/MV | | | 1/2 | 50A9 | | FEBRU | ARY | 1, 1996 | | |
| | | 1 | 30. Name and address of person who | completed cause of d | eeth (Item 23a) | (Type, Prin | 1) | V / | | - LDRO | | , | | |
| | | | Pamela M. Mulshin | | | | d Driv | ve, Silver | Spring, | MD 20 | 901 | | | |
| | Sta | | 31. Dete filed (Month, Dey, Year) | Julia a hur | er's Signature | e? | | | | | | | | |
| | Registr | ar | FEB 02 1996 | Jana apano | WANTE AND AND AND AND AND AND AND AND AND AND | ~ | ·· <u>-</u> | | | | | | | |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

| Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | Certifica | ate of | Death | | Re | eg. No | | | | |
|--|----------|--|-------|--|--|---------------------------|---|-------------------------|-----------------------------|--------------|---|---------------------------|-----------------------------|------------------------|----------|--|
| EXAMPLE SALE SALE SALE SALE SALE SALE SALE SA | | | | 1. Decedent's Neme (First, Middle, L | ast) | | | | | | 2. Dete of Deet | h | | 3. Time of D | leath | |
| # Cettly Noted Control | | | | EMIL | ROYO | 0 | | | | | JAN. 29 | | Year | 1111 | | |
| Control Cont | Ŋ. | | | 4a. Facility Neme (If not institution, g | ive street end number) | | | | 4b. City, To | wn, or Lo | | 1 | y of Death | | | |
| Source Security Number Class | М | 2,01111 | | 6612 TULTP | HILL TERRACE | ē. | | | RET | HESD. | Δ. | MON | JTCOMI | PDV | | |
| ## 49.2 I.B. O.702 X # 87 III. ## 10.5 Cooling To Cooked III. ## 10.5 Cooling To Cooked III. ## 10.5 Cooling To Cooked III. ## 10.5 Cooling To Cooked III. ## 10.5 Cooling To Cooked III. ## 11. National Basines ## 11. National Basines ## 11. National Basines ## 11. National Basines ## 12.5 Was Deposited (point IV.) ## 11. National Basines ## 12.5 Was Deposited (point IV.) ## 12.5 Was De | | Funeral | П | | Sex 7. Age (In | | | | If Under | 24 Hrs. | | | 7 | | Foreign | |
| 150. State 150. County 150. Clay 1 | | | | | 1 X M 2 □ F 8 | 7 | Yrs. Month | Days | Hours | Min. | OCT. 20 | ,1908 | MISSO | DURI | | |
| The content of the | | and and | | | 100 | c. City, Town | n or Location | | | | | | 1 | Od. Inside City | Limits | |
| The content of the | | Be-f sh | ctor | MD MON' | r. | BETHE | SDA | | | | | | | 100 | | |
| The content of the | | F 20 F | - Dic | 10e. Street end Number | | | 10f. 2 | Zip Code | | | 10 | 0g. Citizen of | What Cour | ntry? | | |
| The content of the | | th w 23s | 18 | 6612 TULIP HIL | L TERRACE | | | 208 | 16 | | | U. | S.A. | | | |
| The content of the | | de la la la la la la la la la la la la la | ine | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | in U,S. | 13. Was Dec | cedent of h | Ilspanic Ori | igin? (Spe | ecify Yes or No- Rican, etc.) | | | | | |
| The content of the | 020 | urs after | | | 1 ☐ Yes 2 X No If Yes, Give | | | | | | Thous, otoly | | | | | |
| The share's Name First, Michie, Lead JURAJ ROJKO 10. Making Address (Street and Number of Russ Roses Number) SUZANA STANCE SUZANCE SUZANA STANCE SUZANA STANCE SUZANA STANCE SUZANA STANCE | 15-0 | n 72 ho natur | leted | 15. Decedent's l (Specify only highest g | Education rade completed) | 16a. | Decedent's Us (Give kind of the DO NOT | sual Occup work done | oation during mos | t of worki | ing | 16b. Kind of E | 3usiness/In- | dustry | | |
| The share's Name First, Michie, Lead JURAJ ROJKO 10. Making Address (Street and Number of Russ Roses Number) SUZANA STANCE SUZANCE SUZANA STANCE SUZANA STANCE SUZANA STANCE SUZANA STANCE | 7 | within she | E | Elementary/Secondary (0-12) | | | | | | | | ADCITT | TTPOTT | | | |
| JURAJ ROJKO SUZANA STANCIK 19th Informer's Nemo-Prolifosionable (Type, Print) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 19th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 20th Making Address (Street and Number or Pland Route Number, City or Town, State, 2th Code) 20th Making Address (Street And Number or Pland Route Number, City or Town, State, 2th Code) 20th Donation, 5 Online (Specify) 21 Signature or Function (Specify) 22 Number of Donation (Specify) 22 Number of Donation (Specify) 22 Number of Donation (Specify) 23 State (Specify Number or Pland Route | מ | Hygin Hygin | | 17 Father's Name (First Middle I as | | A | KCHIIEC | TUKE | 1 | or's Name | (Eiret Middle A | | | | | |
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| Committee Comm | | to E t | | | | | | | II Te | rrace | | | | | b | |
| Physician // Medical Examinor Physician // Medical Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician // Medical Examinor Physician | Mor | Pages nent of I mt: if its iry or o | | 1 Burial 2 □ Cremation 3 | ☐Removel from State | cemeter | y, cremetory o | r other ple | | 2 | | | | | | |
| Physician //Midulal Examiner Parkinsons Disease Parkinsons Disea | Balti | Departir Departir Importa any infu | | 21. Signature of Funeral Service Lice | Signature of Funeral Service Licensee 22. Neme and Address of Fecility JOS GAWLERS SONS INC. | | | | | | | | | | | |
| Physician Medical Examiner The part of th | | | | leinow. | Jumos | w | | | | | | | .0016 | | | |
| PNEUMONIA Due to (or as a consequence of): PARKINSONS DISEASE Due to (or as a consequence of): PARKINSONS DISEASE Due to (or as a consequence of): DYSPHAGIA Due to (or as a consequence of): DYS | | | | shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| Due to (or as a consequence of): PARKINSONS DISEASE Due to (or as a consequence of): PARKINSONS DISEASE Due to (or as a consequence of): Days page 20 and propose of the state of the | | | | | nediate Cause (Final | | | | | | | | | | | |
| Due to (or as a consequence of): PARKINSONS DISEASE Sequentially list conditions, at a state of light of ligh | | | | disease or condition | PNEUMONI | Α | | | | | | | i | | | |
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| The state of the s | × | ding p | | | I d | | | | | | | | 1 | | | |
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| 24e. Was an autopsy performed? 24e. Was an autopsy performed? 24f. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No 1 Yes 2 Yes Y | o. | y the | ys | Part II. Other signal cant conditions | contributing to death but no | t resulting in | i the underlying | g cause gr | ven in Parti | l. | | | | | | |
| 24b. Was an autopsy performed? 25c. Vas case referred to medical examiner? 1 | D | that | | | ÷ | | | | | | 1 U Ye | s 2UANO | 3 □ Proi | bably 4 U | hknown | |
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| 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29b. Signature and title of certifiler (Check only one) 29c. License number 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end of certs of person who completed cause of deeth (Item 23e) (Type, Print) Jonathan H. Pincus, M.D. 3800 Reservoir Rd., N.W. Washington D.C. 20007 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | ב | | on: | _ | 28a. Date of Injury (Month, Dey Yea | 28b. T | njury | | | 1 | 28d. Describe ho | w injury occu | rred | | | |
| 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29b. Signature and title of certifiler (Check only one) 29c. License number 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end of certs of person who completed cause of deeth (Item 23e) (Type, Print) Jonathan H. Pincus, M.D. 3800 Reservoir Rd., N.W. Washington D.C. 20007 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | 200 | | cati | 2 Accident investigation | | | М | 1 🗆 | Yes 2□ | No | | | | | | |
| 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29b. Signature and title of certifiler (Check only one) 29c. License number 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end of certs of person who completed cause of deeth (Item 23e) (Type, Print) Jonathan H. Pincus, M.D. 3800 Reservoir Rd., N.W. Washington D.C. 20007 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | ₹ | | ŧ | determine | 286. Place of injury - | At home, far | rm, street, fact | ory, office | | 1 | | | ber or Rura | Il Route Numbe | or, | |
| 30. Name end and the of person who completed cause of deeth (Item 23e) (Type, Print) Jonathan H. Pincus, M.D. 3800 Reservoir Rd., N.W. Washington D.C. 20007 State 31. Date filed (Month, Dey, Year) 32. Registrar's Signature | | a safe | C | | | | | | | | | | | | | |
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| 30. Name end and the of person who completed cause of deeth (Item 23e) (Type, Print) Jonathan H. Pincus, M.D. 3800 Reservoir Rd., N.W. Washington D.C. 20007 State 31. Date filed (Month, Dey, Year) 32. Registrar's Signature | | omple of the | | 29b. Signature and title gl-g#tifler | 1 -2 | 17 | 2 | 9c. Licens | e number | | 25 | 9d. Dete sign | ed (Month, | Day, Year) | | |
| 30. Name end of person who completed cause of deeth (Item 23e) (Type, Print) Jonathan H. Pincus, M.D. 3800 Reservoir Rd., N.W. Washington D.C. 20007 State 31. Date filed (Month, Dey, Year) 32. Registra's Signature | | P S P O | | 160 | In AM | has | - | 61.1.6 | | | | | | | | |
| Jonathan H. Pincus, M.D. 3800 Reservoir Rd., N.W. Washington D.C. 20007 State 31. Date filed (Month, Dey, Year) 32. Registrar's Signature | | | | 1/1/1 | " u //// | In | | 10440 | | | J | AN. JU, | ספעו | | | |
| State 31. Date filed (Month, Dey, Year) 32. Registrar's Signature | | | | | · · | | | | | | | | | | | |
| LAN OI 1000 AL MALLER LINE | | | | | | | servoir | Rd. | , N.W | . Was | shington | D.C. | 20007 | | | |
| HEODSIGN AND 1990 SOUNCEST TOURSE | | Sta Registr | | | 1996 32. Hogistrar's S | uccessor | Carolalle | | | | | | | | | |

STEEL A SECTION AND

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 4 | FOR STATE REGISTRAR |
|---|---------------------------|
| ľ | 1. DECEDENT'S NA |
| l | EDN |
| ľ | 4. SOCIAL SECURIT |
| l | 203-12- |
| Ī | 9a, FACILITY NAME |
| | Washing |
| ľ | RESIDENCE C |
| I | 10e. STATE |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| | REGISTRAN | | 01 | -141-4 | OAIL | | | HEG. NO. | | | | |
|---------------|--|-------------------------------|---------------------------------|--------------|-----------------|-------------------------|---------------------------------------|---|-------------|---------------|--|--|
| ŀ | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH DA | | YEAR | 3. TIME OF DEATH | |
| - 1 | EDNA R. | RHODE | | | | | | January 24 | , 19 | | 2146 M | |
| | 4. SOCIAL SECURITY NUMBER 203–12–7831 | 5. SEX 8 | AGE (In yrs. les | | IF UNDER 1 YE | | MIN. | JULY 9, 191 | 16 | Penr | PLACE (State or Foreign TSylvania | |
| 1 | 9a. FACILITY NAME (If not Institution, give st | treet end number) | | | 9b. CITY, TO | WN OR LOCA | TION OF DE | ATH | 9c. COU | NTY OF D | EATH | |
| FOR | Washington Advent | tist Hospi | tal | | Tak | koma P | ark | | Mont | gome | ery | |
| <u>a</u> | 10e, STATE 10b, COUNTY | 1 | | 10c. CITY. | TOWN OR L | OCATION | | | | | 10d, INSIDE CITY | |
| DIRECTOR | | e Georges | | Adel | phi | | | | | | t YES 2 X NO | |
| FUNERAL | 100. STREET AND NUMBER 8311 26th Place | | | | | 101. ZIP CO 207 | | | | J.S.F | WHAT COUNTRY? | |
| N. | 11. MARITAL STATUS | 12. WAS DECEDENT | FV60 (N. 11.0. A. | | I so uno | | | IIC ORIGIN? (Specify Yea | | | | |
| BY FU | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 FYES, OIVE WAR | YES 2 X | | If ye | | en, Mexica | n, Puerto Rican, etc.) | or No— | Bleck Spec | E — American Indian, k, White, etc. //////////////////////////////////// | |
| | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DE | CEDENT'S L | SUAL OCCU | PATION g most of wor | l-l | 16b. KIND OF BUS | SINESS/INC | DUSTRY | | |
| E | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | Do NOT use | retired.) | | | | | | | |
| BESCOMPLETED | | 2 | Ord | ders (| 3ranch | | | or Dept. of | | ense | e/USAF | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) T. G. Steckman | | | | | Ann | | ME (First, Middle, Melden ehring | Sumeme) | | | |
| | 19a, INFORMANT'S NAME (Type/Print) | | 10 | S MAILING | ADDRESS (St | | | Still 1119 Soute Number, City or Town | - Ctata 7/e | Cadai | | |
| 2 | J. William Rhodes | | | | | L. Ade | | | _ | , (0000) | | |
| | 20c. METHOD OF DISPOSITION 1 M Burlel 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 4 Donetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DISPOSITION (Name of particular of cliffer place) 20b. PLACE AND DATE OF DATE O | | | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012 | | | | | | | | | | | |
| | Juja 11 |) lela | ach | | | | | . NW Washi | ingto | n,DC | 20012 | |
| | 23. PART I. Enter the disesses, or a ahock, a heart failure. | | | | ot enter the | mode of d | ying, suc | h ss cardlec or respi | iratory sn | rest, | Approximate interval Bstween | |
| | disease or condition CERERRO VASCULAR ACCIDENT | | | | | | | | | | Onset and Death | |
| | resulting in death) S. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | 1-21-76 | | |
| _ | Sequentially list conditions a ATRIAL FIBRILLATION | | | | | | | | | | 1-21-91 | |
| CERTIFICATION | Sequentistly list conditions, if any, isading to immediate | DUE TO (C | OR AS A CONSE | OUENCE OF |): // | | | | | | | |
| 2 | Cause. Enter UNDERLYING C. AS PIRATION PNEUMONIA Due to (or as a consequence of): | | | | | | | | | | 1-21-96 | |
| Ħ | that initiated events reaulting in death) LAST | H 1/ | NS . | | | | 12161 | | | | | |
| 8 | | d. /// | 1016 | 1071 | TN | | | | | | 1-61-4-6 | |
| | PART II. Other significant condition | ns contributing to d | eeth but not | resulting in | n the under | lying cause | given in | Part I. 24a, WAS AN PERFOF | | 248 | b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO | |
| EDICAL | | | | | | | | t TYES 2 | 100 | | OF DEATH? | |
| NE NE | | | | | | | | ' | • | | 1 YES 2 NO | |
| ä | DID TOBACCO USE CONT | RIBUTE TO CAU | | | | | CERTAII | и 🗆 📗 💮 | | | | |
| 20 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | | e e e e e e e e e e e e e e e e e e e | | | | | |
| PHYSICIAN: | t YES 215 NO | 28e. DATE OF II | | 28b, TIME | | Home 5 L | Residenca | 8 ☐ Other (Specify) 28d, DESCRIBE HOW I | INJURY OC | CURED | | |
| BY PI | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day | | INJ | JRY | WORK? | □ NO | | | | | |
| 0 | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF building, at | INJURY — At he ic. (Specify) | ome, tarm, s | treet, factory, | office | | 28t. LOCATION (Street of City or Town, State) | | r or Rural | Route Number, | |
| 9 | 290. CERTIFIER CERTIFYING PHYS | ICIAN: To the best of m | v knowledge, d | eath occurre | d at the time | date and pla | ce, end due | to the ceuse(e) end me | nner ee ata | rted. | | |
| COMPLETE | (Critica Crity D | - 1 | | | | | | | | | s) end manner ee stated. | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | | 7 | | | | 16ENSE NUI | | | | RV75.199L | |
| 10 | 30. NAME AND ADDRESS OF PERSON WE | HO COMPLETED CAUSE | OF DEATH (ITE | M 27) (Type, | Print) | UF | 1176 | = 38 n. TA | Vala | 12 | RY25,1996 OK, MD 20912 | |
| | 31. DATE FILED (Month, Day, Year) | JE NEGISTRAN | S SIGNATURE | 2.10 | L-4 /1 | 12,0 | 7116 | 11/1/ | COM | TAK | 1,110 | |
| | JAN 29 1996 | Julia d'au | when have | tall | | | | | | | | |

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|--|
| TO THE HO | TO THE FU | be filed wit | IMPORTA |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTI | | | MENTAL HYG | | | | | |
|---|--|---|--|---------------------|------------------------------------|-----------------------|-----------------------------|-------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEAT | н | 3. T | IME OF DEATH | | |
| , | Joseph | h Sim | pson, Sr. | • | | January | 24,1996 | AR | 1:00 A M | | |
| | 4. SOCIAL SECURITY NUMBER 5. | | yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8.1 | BIRTHPLA | CE (State or Foreign | | |
| į | 215-01-0734 15 | M 2 F 85 | YRS. | DAYS DAYS | HOURS MIN. | June 14 | ,1910 | | yland | | |
| TOR | 8255 Gilroy Road | | | | jemoy | | | arles | | | |
| DIRECTOR | Maryland Charle | S | | OWN OR LOCATI | ON | | | 1,539 | LIMITS? | | |
| | 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g. CITIZEN | | | | |
| FUNERAL | 8255 Gilroy Road | | | | 20662 | | U | S.A. | | | |
| S | | | AS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (SI | | | | | RACE - / | American Indian, | | |
| | t Never Married 2 Married | FORCES? 1 YES | | If yes, spe | city Cuban, Maxica 2 NO Specify | -) | Black, White, atc. Specify: | | | | |
| ВУ | 3 Wildowed 4 Divorced | | | | X | | 9-6 | Cauca | sian | | |
| Ĕ I | 15. DECEDENT'S EDUCATION (Specify only highest grade com | | to. DECEDENT'S US (Give kind of work | k done during mos | N st of working | t6b. KIND O | BUSINESS/INDUST | TRY | | | |
| 9 | | ollege (1-4 or 5+) | life. Do NOT use r | * | | | | - | | | |
| COMPLETED | 7th 17. FATHER'S NAME (First, Middle, Last) | N/A | Plumber | £ | 0. | | lf-Emplo | yea | | | |
| | | G: | | | | ME (First, Middle, Mi | | | | | |
| B | John R. Simpson Minnie H. Johnson | | | | | | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| | Stella Simpson 8255 Gilroy Road Nanjemoy, Md 20662 208. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of OATE 200. LOCATION — City of Town, State | | | | | | | | | | |
| | t T Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify) | from Stata Come | tery, crematory or othe | r place) | meor | 0ATE 20 | Cui+1 a | nwoi no | Marciland | | |
| | Commettery of other (Specify). Cedar Hill Cemetery Jan. 27,1996 Suitland, Maryland 21. Sudmature of uneral serving Oceans. 22. Name and address of Facility Lee Funeral Home, Inc. | | | | | | | | | | |
| - 1 | 10/1/ | 11/ | | | | | erry Rd | | • | | |
| _ | 1/10 K- K | 4 anc | | | | | 2072 | 5 | con, FA | | |
| | 23. PART I. Enter the diseases, or com ahock, or heart failure. List | plications that caused only one cause on as | the deeth. Do not ch line. | t enter the mo | da of dying, auc | h aa cardlac or i | aspiratory arrest | . | Approximata interval Between | | |
| | IMMEDIATE CAUSE (Final | () | 0 | 0 | - 1 | _ | | | Onest and Death | | |
| | disease or condition reaulting in death) a. Cerebral henovelage | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ON | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| F | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| 일 | CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | reaulting in death) LAST | | | | | | | | | | |
| | SAST II ONLY II III | | | | | | | 1 | | | |
| Ä | PART II. Other aignificent conditions of | ontributing to death bu | it not resulting in | the underlying | j cause given in | | S AN AUTOPSY RFORMED? | AVA | RE AUTOPSY FINDINGS ILABLE PRIOR TO | | |
| ă | | | | | | t 🗆 Y | ES 2 NO | | MPLETION OF CAUSE DEATH? | | |
| X | | | | | | | | 10 | YES 2 NO | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIB | | | | UNCERTAI | иП | | | | | |
| 0 | | OSPITAL: | 6. PLACE OF DEATH | OTHER: | | | | | | | |
| ΙΥS | 1 YES 2 NO 1 (| Inpetient 2 ER/Outpe | | | e 5 🗆 Residence | | | - | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME (| NO WO | RK? | 286. DESCRIBE H | OW INJURY OCCUR | ED | | | |
| B | 2 Accident Investigation | 28s. PLACE OF INJURY | - At home form etc | | res 2 No | 285 LOCATION /S | treet and Number or | Over Dove | Alumbas | | |
| | 3 Suicide 8 Could not be determined | building, etc. (Speci | (y) | eet, rectory, orner | | City or Town, | | nurer route | rearriber, | | |
| COMPLET | 29a. CERTIFIER VIA | L | | | | | | | | | |
| M M | (Check only One) CERTIFYING PHYSICIAL ONE) | | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINER: C | THE DESIGN OF EXEMINISTROIT | and/or investigation, | in my opinion, o | | | | | | | |
| ᇤ | 296. SIGNATURE AND TITLIFF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month) | | | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF DERSON WHO C | | TH (175): 07: - | N/1\ | 106 | 107 | 1- | 1 | 11/6 | | |
| | Frederick Johns | on M.D. 201 | Howard | Street : | LaPlata | Md. | | | | | |
| 31. DATE FILED (Month, Day, Your) JAN 3 0 1996 Julia Shutlian Randall | | | | | | | | | | | |

e² o real r

BALTIMORE, MARYLAND 21215-0020

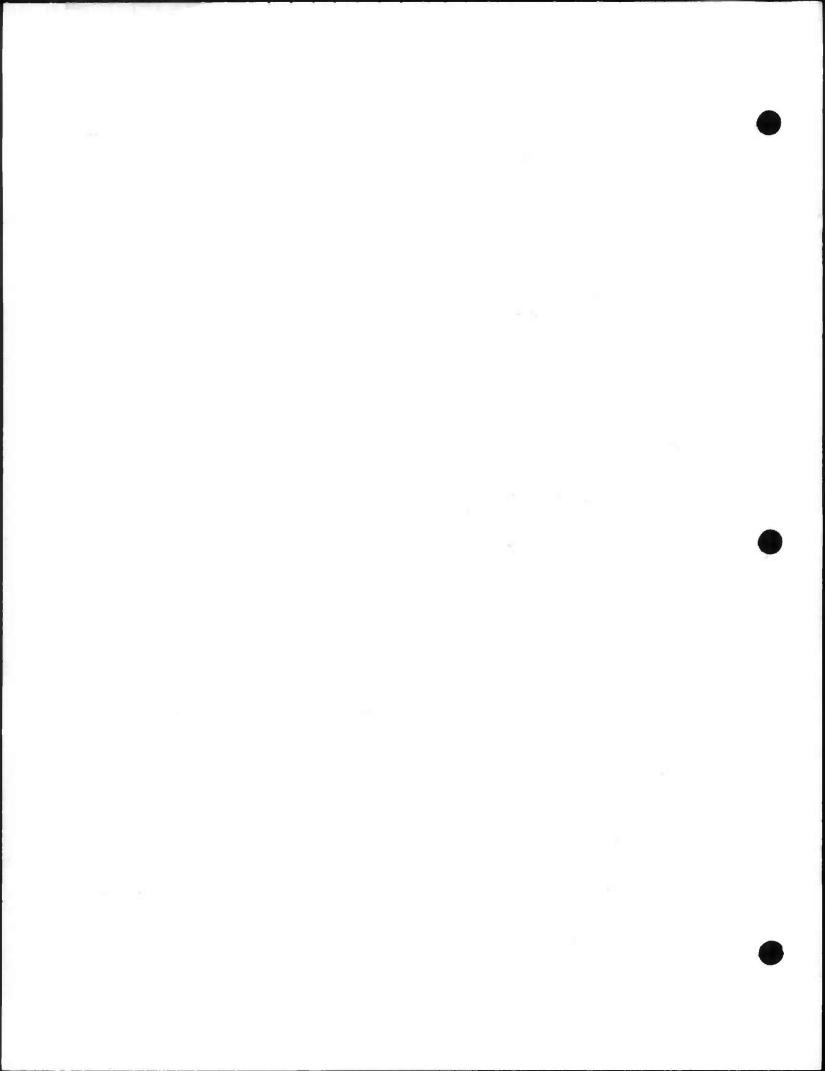
DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. |
|---|
| IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

JAN 31 1996

32, REGISTRAL'S SIGNATURE

| | | | | | | | | | | | | 96 | | 3836 |
|--|--|---|---------------------------|---------------------------------------|-------------|-----------------------------|----------------------|------------------|-------------|---------------|-------------------|------------------------------|-------------|-----------------------------------|
| _ | | 1 - FOR STATE REGISTRAR | STATE OF M | MARYLAND / | | RTMENT | | | | MENTAL | HYGIEN REG. NO | IE . | , . | |
| | - ŝ | 1. DECEDENT'S NAME (First, Middle, Last) | | - | | | | | | 2. DATE C | E DEATH | | 3 | . TIME OF DEATH |
| | | Melvin Augustus S | Schneider | Jr. | | | | | | монтн | an. 2 | 8, 19 | 96 | on live Am |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. las | t birthday) | IF UNDER | 1 YEAR | IF UNDER | 1 24 HRS. | 7. DATE O | E BIRTH | T | . BIRTHPL | ACE (State or Foreign |
| -1 | - 8 | 213-32-7317 | 1 🔀 M 2 🗆 F | 60 | YRS. | MONTHS | DAYS | HOURS | Mire. | Apri | Dey, Year) | 1935 | Mar | yland |
| | | Sa. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, | TOWN C | OR LOCATI | ON OF DE | | | 9c. COUNT | | |
| | 8 | 2032 Green Mill RESIDENCE OF DECEDENT | Rd. | | | | Fi | nksb | ura | | | | Car | roll |
| | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | | | | |
| | <u>E</u> | | | | | Y, TOWN O | | | | | | | _1 | Od. INSIDE CITY LIMITS? |
| | | Maryland Carro | 011 | | | Finks | W | g ZIP COD | - | | | | | ☐ YES 2 🔀 NO |
| | ₩. | | | | | | יטו | . ZIP COU | | | | 10g. CITIZI | EN OF WH | AT COUNTRY? |
| | FUNERAL | 2032 Green Mill I | | Ţ EVER IN U.S. ARI | MED | 142.1 | me DEC | ENDENT C | | 210 | | | | ted States |
| | _ | 1 Never Married 2 Married | FORCES? 1 | YES 2 N | 0 | 1 | yes, sp | ecity Cubs | ırı, Mexica | n, Puerto Ric | (Specify Yes | s or No- | Black, 1 | - American Indian, White, etc. |
| - 1 | B | 3 Widowed 4 Divorced | JAN 1955 | | 55 | Ι, | ☐ YES | 2 K NO | Specify | y: | | | Specify: | White |
| | | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | 16a, DE | CEDENT'S | USUAL OC | CUPATIO | ON | | 16b. I | IND OF BU | SINESS/INDU | STRY | |
| | 9 | Elementary/Secondary (0-12) | College (1-4 or 5 | -) | DO NOT U | work done d se retired.) | | | rig | | | | v. a. | |
| ed | COMPLET | 12 | | Se | rvic | e Mar | iage | r | | | | A | M COI | rporation |
| 9 | 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTI | HER'S NA | ME (First, Mi | ddle, Maiden | Sumame) | | |
| Melvin Augustus Schneider Sr. Mariangela Co | | | | | | | | Caple | | | | | | |
| The parties of the pa | | | | | | | 40 | | | | | | | |
| 9 | | 20e. METHOD OF DISPOSITION | | | _ | _ | | | | | | | | |
| nust | | 12 Buriel 2 Cremetion 3 Remo | oval from Stata | 20b. PLACE A cemetery, cree Sa. | netary or a | of DISPOSI | Chu. | me of | 01/3 | 1/96E | 20c. LO | CATION — CI | | burg, MD |
| Je l | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | i i d y i i | | _ | | | | | | _ | burg, mb |
| cami | | · | , | • | | | | | | | | & Cha | | MD 21157 |
| 28 | | 23. PART I. Enter the diseases, or complications that coulsed the death. Do not anter the mode of dying, such as cardiac or respiratory | | | | | | | | | | , ND 21137 | | |
| B | | snock, or neart tellure. List only one cause on each line. | | | | | | | | | it, | Approximata interval Between | | |
| the state of | | IMMEDIATE CAUSE (Final | | | | | | | | | | | | |
| H, | ł | disease or condition resulting in death) a. AORTIC ANEURYSM RUPTURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | HICS, | |
| 20 3 | <u>,</u> | | | SH BLOOD PRESSURE | | | | | | | | VPC | | |
| E E | 0 | Sequentially list conditions, if any, leading to immediate | | OR AS A CONSEC | | - | | 0,00 | | | | | | YRS. |
| tra | HTIFICATION | cause. Enter UNDERLYING | AS | CVD | | | | | | | | | | YRS - |
| the state of | | CAUSE (Disease or injury that initiated events | | OR AS A CONSEO | UENCE O | F): | | | | | | | | |
| | | resulting in death) LAST | _ 0 | PD | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FI | | | | | | | EDE AUTOROV EINDINGS | | | | | | | |
| any | PERFORMEDY AMALABLE PRIOR TO COMMUNICATION OF PAIN | | | | | | | MILABLE PRIOR TO | | | | | | |
| WS | | | | | | | | | | _ | YES 2 | NO | 0 | F DEATH? |
| 19 | 2 | DID TOBACCO USE CONTR | IBUTE TO CA | LISE OF DEAT | TH YE | SXN | ЮП | LINC | ERTAIN | | | | 1 | YES 2 NO |
| H 23 | Y N | 25. WAS CASE REFERRED TO MEDICAL | DOIL TO CA | | | TH (Check o | | 0140 | EKIMI | 101 | | | | |
| Item | YSICI | EXAMINER? | HOSPITAL: 1 Inpatient 2 | ER/Outpatient 3 | DOA | OTHER 4 Num | | s (Ma) | aldanca | 6 🗆 Other (| Specific) | | | |
| | À HÀ | 27. MANNER OF DEATH | 28a. DATE OF | INJURY | 28b, TIM | E OF | 28c. INJL | URY AT | | | | NJURY OCCU | RED | |
| | 2 | 1 Natural 5 Pending 2 Accident Investigation | (Month, Da | ny, rever) | INJ | URY M | 1 Y | PK? 'E\$ 2 [| NO | | | | | |
| .00 | a II | 3 Suicide 8 Could not be | 28a. PLACE Of building. | F INJURY Al honetc. (Specify) | ne, farm, s | streat, facto | ry, office | | | 28f. LOCAT | ION (Street a | and Number or | Rural Rou | te Number, |
| 2 | <u>"</u> | 4 Homicide determined | | (| | | | | | City or | iown, state) | | | |
| Tem | COMPLE | 29a. CERTIFIER (Check only | IAN: To the best of | my knowledge, das | th occurr | d at the tir | ne, data | and place. | and due | to the cause | (s) and mar | mer as stated | | |
| IMPORTANT: 11 | 5 | one) 2 MEDICAL EXAMINER | : On the basis of ax | amination and/or in | vestigatio | n, In my op | inlon, de | eath occur | ed at the t | time, deta at | nd place, an | d dua to the | cause(s) as | nd manner as stated. |
| E S | u II | 296. SIGNATURE AND TITLE OF CERTIFIER | -0- | | | | | | NSE NUM | | | | | onth, Day, Year) |
| # Phreep N. Phreep M.D. D36908 1/30/96 | | | | | | 196 | | | | | | | | |
| | = | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITEM | 27) (Type. | Print) | | - | _ | | | / | | |



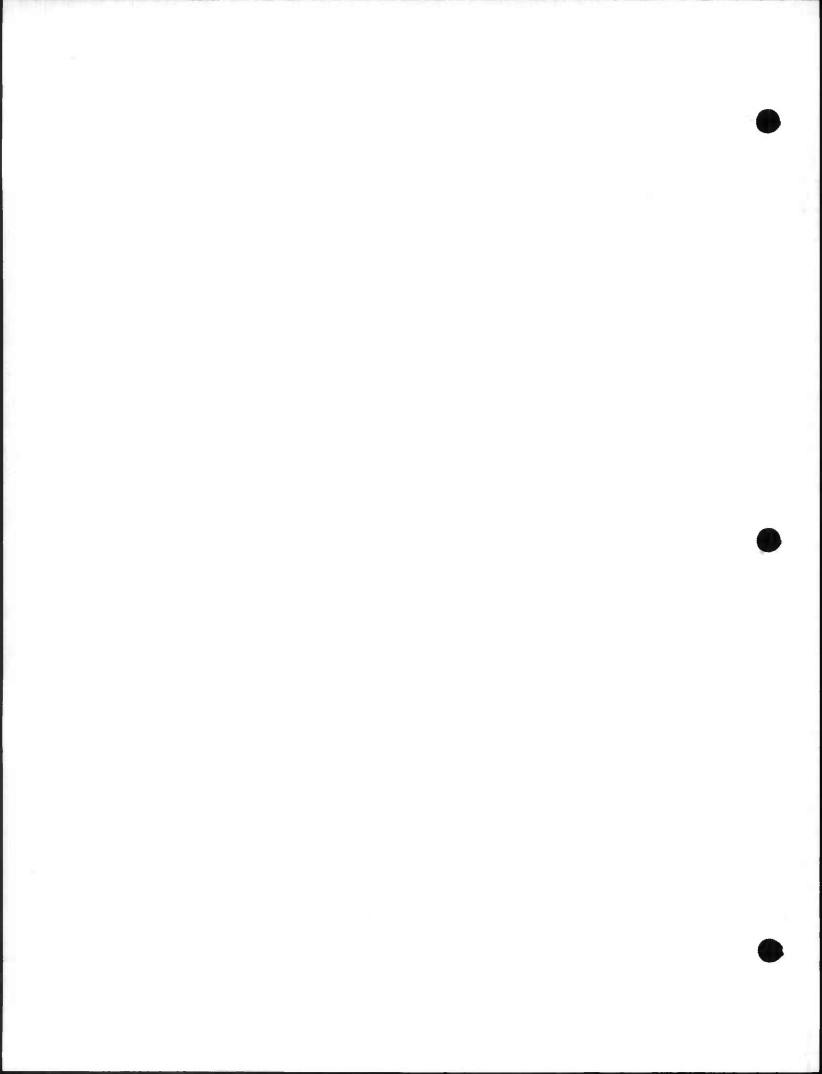
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunta-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | REGISTRAN | | CENTIL | ICALE | OF DEATH | REG. NO. | | | | | |
|---------------|---|---|----------------------------------|-------------------------|---|--|---|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | EDNA CARI | RIE STUL | 1 | | 2. DATE OF DEATH MONTH DA | | YEAR 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER | | | | | JANUARY 29 | | | | | |
| | 74 100 700 000 000 000 000 | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YE MONTHS DA | | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) | | | |
| | 219-36-3037 Se. FACILITY NAME (If not institution, give si | Δ | 94 YRS. | | | MARCH 22, | 1901 | MARYLAND | | | |
| œ | | | | | WN OR LOCATION OF DE | EATH | | TY OF DEATH | | | |
| 0 | ST. CATHERINE:S | NURSING CEN | TER | EMMI | TSBURG | | FRI | EDERICK | | | |
| <u>n</u> | 10a. STATE 10b. COUNTY | 1 | 10c. CIT | Y, TOWN OR L | DCATION | | | 10d. INSIDE CITY | | | |
| DIRECTOR | MARYLAND FREDE | ERICK | E | MITSBU | JRG | | LIMITS? | | | | |
| | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| FUNERAL | 331 SOUTH SETON A | AVENUE | | | 2172 | 27 | | USA | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | | | NIC ORIGIN? (Specify Yes | or No- | 14. RACE — American Indian, Black, White, etc. | | | |
| ВУ Б | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 TYES | | | s, specify Cuban, Mexica YES 2 XNO Specify | | | Specify: | | | |
| | | | | | | | | CAUCASIAN | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a. DECEDENT'S (Give kind of | work done durin | PATION g most of working | 16b. KIND OF BUS | SINESS/INDU | JSTRY | | | |
| <u>ا</u> ا | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | | TD. | | | | | | |
| × | 6th 17. FATHER'S NAME (First, Middle, Last) | | SCHOOL | TEACHI | | EDUCATI | | | | | |
| | DANIEL ALLEN | STULL | | | FMMA | JANE | Sumame) WITH | ETD OW | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | - BIOLES | 100 MAII INC | ADDRESS (De | | Aoute Number, City or Town | | | | | |
| 2 | WILBUR W. STULL | | | | TOWN PIKE | TANEYTOWN | | | | | |
| | 20a. METHOD OF DISPOSITION | 20 | b. PLACE AND DATE | _ | | | | City or Town, State | | | |
| | 1 N Buriel 2 Cremation 3 Remo | | metery, crematory or c | | | 1 . | | WN, MARYLAND | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | Olarch O.C | | | | DATE | TIMODE CODEED | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MD 21787 | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| | shock, or heart failure. | List only one cause on | aach line. | not enter the | mode or dying, suc | n as cardiac or reapi | ratory arre | Interval Between | | | |
| ŀ | IMMEDIATE CAUSE (Final disease or condition resulting in death) | | | | | | | | | | |
| | disease or condition a. United (or as a consequence of): Dut to (or as a consequence of): All detterments and 2 yrs Dut to (or as a consequence of): | | | | | | | | | | |
| - | | 0 | | | Del | 0.1 | | 241. | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE O | F): | | Jones | | | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | 0 | | | | | |
| E | that initiated events | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | | | |
| ᇤ | resulting in death) LAST | d | | | | | | | | | |
| | PART II. Other aignificant condition | a contributing to death | but not resulting | in the under | ving cause given in | Part I. 24s. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | |
| DICAL | Cherry | Olista | unti | 1114 | a Digos | MED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| LU II | Convers | tue de | A FA | ilai | W IA -CO | 1 D YES 2 | DI NO | DF DEATH? | | | |
| Σ | DID TOBACCO USE | | CALISE OF | DEATH | YES NO |) F71 | | 1 YES 2 NO | | | |
| A I | 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE TO | CAUSE OI | | 8. PLACE OF DEATH (Ch | الجا | | | | | |
| Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: | tostlent 3 DOA | OTHER: | Home 5 - Residence | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIN | IE OF 28c | INJURY AT | 28d. DESCRIBE HOW II | NJURY OCC | URED | | | |
| | 1 Natural 5 Pending Investigation | (Month, Day, Year) | in. | M 1 | WORK? | | | | | | |
| р ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJUR building, atc. (Sp | IY — At home, ferm, | street, factory, | office | 281. LOCATION (Street a | and Number | or Rural Route Number, | | | |
| E | 4 Homicide determined | ounding, are, (ap | өспуј | | | City or Town, State) | | | | | |
| 7 | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my kno | wledge, death occurr | ed at the time. | data and place, and due | to the cause(s) and man | ner as atale | id. | | | |
| COMPLETED | | | | | | | | cause(s) and manner as stated. | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 111 | A | 111 | 29c. LACENSE NUI | | | SIGNED (Month, Day, Year) | | | |
| 98 | | (ILLA) | 10111 | XI M | 1 118 | 205 | DATE | 1/30/9/ | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF D | EATH (ITEM 27) (Type | . Print) | UL O | 103 | | 1 20110 | | | |
| | ALAN CARROLL, M. | D 310 S. | SETON AV | /E. FN | MITSBURG, | MD. 21727 | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE | | | 1/-/ | | | | | |
| | JAN 3 1 199 | 6 Jahr Dave | leon Randall | | | | | | | | |



96-0339-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are

State of Maryland / Department of Health and Mental Hygien 06 03838

| | | | | | • | Cer | tificate of | Death | F | Reg. No. | O | 03030 |
|-------------------|--|----------------|---|--|----------------------------|-------------------------------|---|---|------------------------------------|------------------------------------|--------------------------|---|
| Е | | -3 | 1. Decedant's Nama (First, Middla, Last |) | | | | | 2. Data of Dea | ith | 277 | 3. Time of Death |
| | Physici /Medi | | MARY | LYNNE | | | SCHI | JBERT | JANUAR | Y 23,1 | Year 996 | 8:20A.M |
| 7 | Examir | | 4a. Facility Nama (ff not institution, giva | | | | 5011 | 4b. City, Town, or L | | | | 0.2011 |
| | | | PRINCE GEORGES | HOSPITA | L CE | NTER | | CHEVERI | Y | PRIN | ICE (| GEORGES |
| | Funeral | | Social Security Number 8. Se | x 7. Age | e (fn yrs. fe | st birthday) | ff Under 1 Year Months Deys | | 8. Dete of Birtl (Month, Day | | | place (State or Foreign |
| h | Director | | 261-76-1291 | JW ZÃTL | 49 | Yrs. | | | May 5 J | | | nois |
| | pue * | | Usual Rasidance of Decedanf 10a. State 10b. County | | 10c City | Town or Loc | ation | | | | | Od. Insida City Limits |
| | Aaryla | ō | 2 | | rou. Ony, | 701111 01 200 | | | | | | Y∑Yas 2□No |
| | the A | Director | MD Anne Aru | ndel | | Annap | olis 101. Zip Coda | | | 10g. Citizen of V | 10 at Caus | |
| | with | | | | | | | | | | | , |
| | ne 23 | era | 3 Belvedere Cour | 12. Was Decedent E | Ever In U.S. | 13 W | | 1403 Hispanic Origin? (Sr | pecify Yas or No- | Unite | | ates an Indian. |
| 21215-0020 | 72 hours after death with the Maryland natural; or flems 23s or 28s-f show dical Examiner must be notified at | by Funeral | 1 □ Nevar Married XX Married 3 □ Widowed 4 □ Divorced | Armed Forcas? 1 Yas 2 X If Yas, Give Yeer or Datas: | | | Yes, specify Cub ☐ Yas 2 No | Hispanic Origin? (Sp an, Maxican, Puerto Specify: | Rican, atc.) | Blac Specify | ck, Whita, | etc. |
| ŏ | 2 hou | | 15. Decedant's Edu | | | 16a. Decede | ent's Usual Occu | patlon | T | 16b. Kind of Bu | | ite dustry |
| 215 | E 2 | Completed | (Spacify only highest grad | a complated) College (1-4or 5 | 4) | (Giva k lifa. D | and of work done O NOT use ratire | during most of world) | king | | | |
| 2 | | EO | Lionary 70000 daily (0-12) | 5 | 7) | Sales | /Agent | | | Rea1 | Est | ate |
| pu | be filed stal Hygi d other svent, t | Be (| 17. Fathar's Nama (First, Middle, Last) | | | | , | 18. Mother's Nam | e (First, Middla, | | | |
| yla | should be ind Mental marked o | To | unknown | | | | | u | nknown | | | |
| Maryland | and and series | | 19a. fnformant's Name/Ralationship (T) | rpe, Print) | | 19b. Mailing | Addrass (Stree | t and Number or Ru | ral Routa Numbe | r, City or Town, | Stata, Zip | Coda) |
| | 1 and Haalth em 27 | | Earl Schubert, Jr | • | | 3 Pr | ince Geo | rge Stree | | | | |
| altimore, | | | 20e. Method of Disposition 1 □ Burlei 2 ▼ Cremation 3 □ F | Ramovai from State | | | ition (Nama of etory or other ple | | Dete | 20c. Location - | - 1 | |
| Ē | Pag ment ant: ury | | 4 Donation 5 Othar (Spann | | Ft. | | | tory 1/25 | | | | lary1and |
| Ball | permit. Pagas Department of Important: If it any injury or ones. | | 21. Signature of Funeral Bervior Licens | Kuple | | 22. | Name and Addr | of Glouce | M. Tay | lor Fund | eral | Home, Inc. MD 21401 |
| | | Н | 23a. Part1. Enter the disease, or compl shock, or head failure. List only or | igationa that causes | the death. | | | | | _ | 0113, | Approximate |
| | Physician /Medical Examiner | | Immediata Causa (Final disaasa or condition rasulting in daath) | | Mu | Hipl | | Vjupies | | | 1 | Interval Batwaen Onset end Daath |
| | | P. | l and week and a | | Dua to (or | as a consequ | ience of): | | | | | |
| | nsit | min. | | 0 | | | 1 | | | | i | |
| | certificata be axecuted nding physician and usa as the bunial-transit | Examiner | Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Disaase or Injury | | Dua to (or a | as a consequ | iance of): | | | | 1 | |
| 68760, | sicia bur | edical | Causa (Disaase of Injury that initieted evants | | Due to fee a | as a consequ | 2000 06). | | | | | |
| | rtificat ng phy r as th | edi | rasulting in daath) Lest | | Dua to (of a | is a consequ | ence or). | | | | | |
| Box | eath cert attendin | M/C | | d | | | | | | | | |
| | death e attan | icia | Part II. Other aignificant conditions cor | stributing to death bu | it not result | ing in the un | darlving causa gi | van in Part I | 23b. Did to | obacco use cor | ntribute to | the cause of death? |
| P.O. | tha y th | Physician/ | | and the second of | 110114001 | and an and an | ourry ing occoon gr | VALUE OF CALL TO | 101 | Δ/ | 3 □ Proi | |
| | s that gned b | ру Р | | | | | | | | 740 | | |
| of Vital Records, | requii | Completed | | | | | | | 24a. Was a perfor | an autopsy med? | ev. | ara autopsy findings ailabla prior to mpletion of cause daath? |
| Ä | 6 - 0 | EO | | | | | | | 100°Y | as 2□No | 1/3 | Yas 2□ No |
| ta | ulclan: The cartificate rector, pag | BeC | 25. Was casa rafarred to madical | - | | | | 26. Place of Dae | | | - | ~ |
| > | 5 00 | ToE | examinar? | lospital: | nt 2 💢E | R/Outpatient | 3□ DOA Ot | hor | oma 5 🗆 Rasid | | ar (Specif | y) |
| | g Physia tar this | | 27. Mannar of Death | 28a. Data of fnjur (Month, Day | y Year) 2 | 8b. Tima of Injury | 28c. Inju Wo | | 28d. Dascribe h | | | 1 ~ |
| 0 | Attending ir death. ector: Aftai by the funa | atic | 1 Natural 5 Panding 2 Accidant Invastigation | | 6 | 0729 | | Yas 2XNo | Driver | in au | toa | culent |
| Division | of or Atte | Certification: | 3 ☐ Sulcida 6 ☐ Could not ba 4 ☐ Homicida datamined | 28a. Piace of Inju building, atc | ry - At hom . (Specify) | STA | at, factory, office | | 281. Location (S City or Tow | | er or Rura | Route Number, |
| | To the Hospital or Attending Phymin 24 hours aftar death. To the Funeral Director: Aftar thi complataly filled in by the funaral | edical | 29a. Cartifiar 1 ☐ Cartifying Physical Cartifian (Check only one) 2 ☐ Medical Examination | efcian: To the bast oner: On the basis of end mennar sta | axaminatio | edga, daath en and/or inva | occurred at the ti astigation, in my | ma, data and placa, opinion, death occur | and dua to tha cred et the tima, c | cause(s) and ma data and place, | innar as s and dua to | tated. tha causa(s) |
| | within To the | Me | 29b. Signature and title of certifier | / ^ | | Λ | 29c. Lican | sa number | 1 | 29d. Data signe | d (Month, | Dey, Year) |
| | ,-,-0 | | >// Nim | (17) KO | MI | () | | O.C.M.E. | Т | ANUARY | 21 | 1996 |
| | | } | 30. Nama and address of parson who co | empleted cause of | ath (Item 3 | 23a) (Type P | | ,.c.n.E. | D. | ANUANI | 27, | 1000 |
| | | | The American | CE, M |) | | | treet. B | altimo | re, Ma | ryla | and 21201 |
| | Sta | | 31. Data tilad (Month, Day, Year) | 32. Registra | r's Signatu | | | | | -, | 2 | |

Registrar

JAN 30 1996 John Studien Randell

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE 2 3 Suicide

4 Homicide

| | Page | |
|---|--|--|
| | ermit. | |
| an. | ar this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pag | |
| 3 PHYSICIAN: The law requires that the death certificate be executed with mours after death. Page 6 may be retained by the hospital or attending physician. | burial | |
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| B 3v | has | Ded |
| Ē | ate | th with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IAN | rtific | s e |
| YSIC | S Ce | 4 |
| F | T This | J. W. |
| 673 | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

should

1, 2, 3 notified at must be examiner medical the event, traumatic other any Shows 23 Item 0 marked, E HOSPITAL OR ATTENDING I E FUNERAL DIRECTOR: After d within 72 hours after death IRTANT: If Item 28 Is mai TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 hr IMPORTANT: If It

96 03839 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH HassanSHUKRI 00 SUHAYI 96 OM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) BIRTHPLACE (State or Foreign
Country) DAYS HOURS XXM 2 F 219-92-7916 YRS. 31 Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Meridian Health Care Center, Spa Crk. Annapolis Anne Arundel RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE MD 1XXYES 2 NO Anne Arundel Annapolis 10e. STREET AND NUMBER 101. ZIP CODE 966 Breakwater Drive 21403 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 7 HO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 XXO Specify: Specify: White 3√ Widowed 4 □ Divorced 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Broker Insurance/Banking 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hassan Shukri Fatima Al-Khalil 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zein Sheehan 966 Breakwater Drive Annapolis, MD 21403 20e. METHOD OF DISPOSITION
XIX Burlel 2 Cremetion 3
4 Donation 5 Others 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stats DATE Donation 5 Other (Specify) Samir Cemetery 2/4/96 Haifa, Israel 22. NAME AND AODRESS OF FACILITY John M. Taylor Funeral Home STONATURE OF FUNERAL SERVICE LICENSEE 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases, or comp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart fellure. List only one cause on each line. **Onset and Death** IMMEDIATE CAUSE (Final Bladder Concer disesse or condition resulting in death) Metastatic DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 27 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA rrsing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28b. TIME 28d. DESCRIBE HOW INJURY OCCURED 1 Natural Accident 1 YES 2 NO

29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and meni

24a. WAS AN AUTOPSY PERFORMED?

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

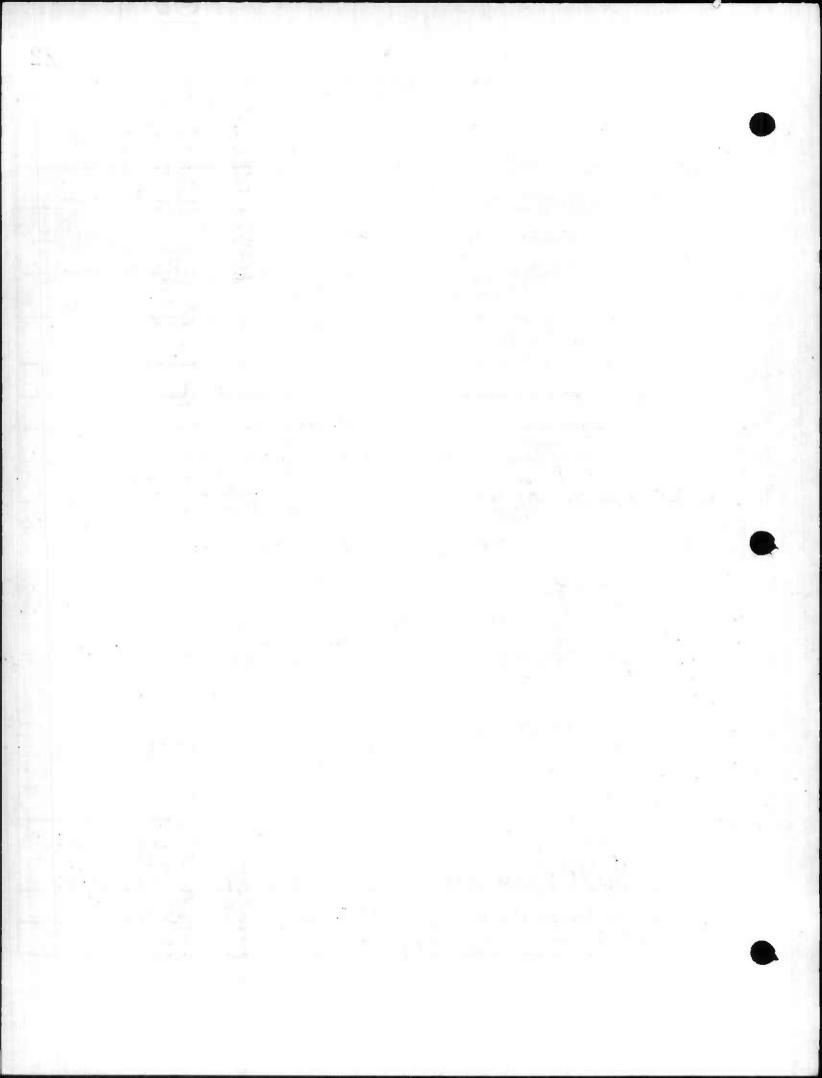
| 296. SIGNATURE AND TITLE OF CUSTIFIER | 1111 110 | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---------------------------------------|----------|---------------------|-------------------------------------|

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ENSER 32. REGISTRAR'S SIGNATURE 31. DATE FILEO

Bereite no

8 Could not be



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH, DAY YEAR 3. TIME OF DEA | | | | | | | | | | | | TIME OF DEATH | |
|----------------------|--|------------------------|---|--|------------------|--|-----------------|---------------------------------------|----------------------------------|----------------------------|---------------------------|----------------------|---------------------------------|--|
| | Andrew Stanton JAN-21-9617 | | | | | | | | | | 1:500 | | | |
| | 4. SOCIAL SECURITY NUM | | 5. SEX | 6. AGE (In yrs. I | | F UNDER 1 Y | EAR IF UI | NDER 24 HRS. | 7. DATE OF (Month, De | | - | BIRTHPLA Country) | ACE (State or A eign | |
| | 212-24-39 | | 1 N 2 F | X | YRS. | | | | 109- | 11-0 | 58 | Ma | k | |
| œ | LAUREL Rec | institution, give s | Hospita | 7300V | an Duge | in Ra | WN OR LO | CATION OF D | EATN | | 9c. COUNT | Y OF DEAT | 'N | |
| DIRECTOR | RESIDENCE OF DE | , | | 1 | | | Lai | re | | | 15 | PG Co | | |
| REC | 10s. STATE | | | | | | LOCATION | | | | | 10 | d. INSIDE CITY LIMITS? | |
| - 1 | Maryland | | e George | | Lau | rel | | | | | | 1 (| X YES 2 NO | |
| 3AL | 10e. STREET AND NUMBER | | | 101, ZIP CODE | | | | | | | N OF WHA | T COUNTRY? | | |
| FUNER | 201 10th St | reet | 12. WAS DECEDENT | | | 20707 RMED 13. WAS DECENDENT OF HISPANIC | | | | | USA | | | |
| | 1 Never Married 2 | Married | FORCES? 1 | YES 2 | KNO | es, specify (| an, Puerto Rica | in, Puerto Ricsn, etc.) Black, Whits, | | | | | | |
| В | 3 Widowed 4 Div | rorced | IF TES, GIVE W | AH ON DATES | | '' | TES 2 X | NO Specif | ny: | | | te | | |
| 9 | 15. DE (Specify of | CEDENT'S EDU | CATION completed) | (Give kind of work done during most of working | | | | | | | KIND OF BUSINESS/INDUSTRY | | | |
| ET | Elementary/Secondary | (0-12) | College (1-4 or 5 + |) | life. Do NOT use | | | - | | | ~ | | | |
| COMPL | Grade 8 | Adjustin (and) | | Ma | chinis | t | | | Uni | | | GOV | ernment | |
| - | Ellsworth S | | | | | | | | Belle | | | | | |
| BE | 190. INFORMANT'S NAME | | | | 19b. MAILING A | DDRESS (S | | | Route Number, | | | ode) | | |
| 2 | Patricia S. | Higgi | ns | | 727 M | cNeil | Lane | , Sil | ver Sp | ring | Mary | land | 20905 | |
| | 20s. METNOD OF DISPOSI | TION | | | E AND DATE OF | DISPOSITION | ON (Name of | | y or Town, | | | | | |
| | 4 Donation 5 Doth | or (Specify) | | Tvy | Hill C | | | | | Lau | cel, M | aryl | and | |
| | 21. SIGNATURE OF FUNER | AL SERVICE LI | CENGER 11 | | | | | DRESS OF F | | P.A. | | | | |
| | * XIW | | neral Home, P.A. Ave. Laurel, Maryland 20707 | | | | | | | | | | | |
| | 23. PART I. Enter the shock, or | distante, or feathers. | complications that List only one cau | ceused the | death. Do no | t enter th | e mode of | dying, suc | ch aa cardiad | or reapi | ratory arrea | nt, | Approximsta Interval Between | |
| - 1 | IMMEDIATE CAUSE (F | 100 | Λ | and the second | 9 | | 0. | 0 | | | | | Onset and Deat | |
| | disease or condition resulting in death) a Respublication tailure | | | | | | | | | | week | | | |
| _ 1 | | _ | Pa | (op as a cons | HIGUENCE OF | D | | | | | | | 2/20 | |
| RTIFICATION | Sequentially list cond | | DUE TO | OR AS A CONS | EQUENCE OF) | | | | | | | | -12.01(6 | |
| S | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | |
| | CAUSE (Disease or Injury that Initiated events particularly and the Initiated events particularly indepth LAST | | | | | | | | | | | | | |
| CER | resulting in death) LAST | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART il. Other signific | ent condition | s contributing to | death but no | t resulting in | the unde | rlying cau | se given in | Part I. 24 | la. WAS AN | | | ERE AUTOPSY FINDINGS | |
| | 12 | ma | l'fa | lus | <u></u> | 1 TYES 2 | | | | | | COMPLETION OF CAUSE | | |
| | | | | | | | | | | | YES 2 NO | | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN | | | | | | | | | | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | | |
| | t ☐ YES 2 ☐ NO | | | | | | | | 28d. DEŞCRIBE HOW INJURY OCCURED | | | | | |
| ВУР | 1 Natural 5 | Pending Investigation | (Month, Di | ay, Year) | INJU | | WORK? | 2 NO | | | | | | |
| | 3 Suicids 8 | Could not be | 28e. PLACE Of building, | F INJURY At atc. (Specify) | home, farm, st | reet, factory | , office | | | ON (Street a | and Number o | Rural Rout | te Number, | |
| ETEL | 4 Homicide | determined | | | | | | | | | | | | |
| COMPL | | MIFYING PNYS | ICIAN: To the best of | my knowledgs, | death occurred | at the time | e, dats and p | olacs, and du | s to the cause | (s) snd mer | nner as stated | f. | | |
| Š | one) 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state- | | | | | | | | | | | | | |
| BE | 296. SIGNATURE MET TO SEE OF CERTIFIER 296. DATE S | | | | | | | | | SIGNED (Month, Clay, Year) | | | | |
| 2 | 30, NAME AND ADDRESS | W PERSON W | O COMPLETED CAL | allering Aligned D06644 Jan 22, 19 | | | | | | | | 2,1996 | | |
| | B. W.G | attic | 8037 | _aure | Lake | 5/0 | ourt | 100 | rel I | MD | 12 | 070 | 7 | |
| į | 31. DATE FILED (Month, Da | | 32 REGISTRA | R'S SIGNATURE | | 5 00 | regin I | -(() | 101, 1 | עוי | =(| 110 | 1 | |
| | JAN 2 | 5 1996 | Julia at | water R | entall | | | | | | | | | |
| | | | 0 | | | | | | | | | | DHMH-16 Rev 1 | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | REGISTRAR | CERTIFI | CALE | F DEATH | REG. NO. | | | | | | | |
|-----------------|--|---|--|---|--|-----------------------------------|--|--|--|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Lest) ROSY ROSEY Latitia SNYDER 2. DATE OF DEATH MONTH DAY YEAR 7/1 | | | | | | | | | | | |
| | | yrs. last birthday) | IF UNDER 1 YEAR | R IF UNDER 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) Oct. 15, 1 | T | 8. BIRTNPLACE (State or Foreign Country) Pennsylvania | | | | | |
| J.R | 9a. FACILITY NAME (If not institution, give street end number) Laurel Regional Hospital | | 9b, CITY, TOW Laur | N OR LOCATION OF DE | | 9c. COUNTY OF DEATH Prince George | | | | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| DIRECTOR | 100. STATE 100b. COUNTY 100c. CITY, TOWN OR LOCATION 100d. INSIDE CITY LIMITS? Maryland Howard Savage 100d. INSIDE CITY LIMITS? XX YES 2 □ | | | | | | | | | | | |
| FUNERAL | 8876 Lincoln Street | | | 101. ZIP CODE 20763 | | | ZEN OF WHAT COUNTRY? | | | | | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried 3XXWidowed 4 Divorced 12. WAS DECEDENT EVER IN 1 FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 X NO | If yes, | DECENDENT OF HISPAN specify Cuben, Maxicer (ES 2 NO Specify | , Puerto Ricen, etc.) | or No- | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| | 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16s. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | |
| BE COMPLETED BY | (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8 College (1-4 or 5+) | (Give kind of w life. Do NOT usi Housey | e retired.) | most of working | Own Ho | Iome | | | | | | |
| NO. | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NAM | AE (First, Middle, Meiden | Sumeme) | | | | | | |
| C | Orie McAfoose | | | Nora Ma | ay Chrissm | an | | | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | | et end Number or Rural R | | | | | | | | |
| F | Lois Kaufman | | | eld Lane | Bowie, Ma | - | | | | | | |
| 1 | 20c. METHOD OF DISPOSITION XXBurlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Completely Secure of the place) Meadowridge Memorial Park 20c. LOCATION — City or Town, State Dorsey, Md. | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. | | | | | | | | | |
| | areyers. Fig | | | Talbott | | | | | | | | |
| | 23. PART I. Enter the diseases, or complectione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Liet only one cause on each line. Approximats interval Between | | | | | | | | | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Fine) disease or condition resulting in deeth) Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERIVING CAUSE (Disease or injury that initiated events resulting in deeth) LAST Cerebral infarction (Cerebrovascular Accident) to Dry Atheroscleratic Vascular Disease Se veral years Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| اير | PART ii. Other significant conditions contributing to deeth but | t not resulting i | n the underl | ring ceuse given in | | | 24b. WERE AUTOPSY FINDINGS | | | | | |
| EDICAL | Noninsulin Detenden | | beto | Melilus | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
| MEC | Corchary Artery Dinease; Hypertension 10 yes 20 NO DF DEATH? | | | | | | | | | | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | DEATH YE | S INO | UNCERTAIN | 1 🗆 | | | | | | | |
| PHYSICIAN: | 26. WAS CASE REFERRED TO MEDICAL EXAMINER? EXAMINER? | | | | | | | | | | | |
| YSI | HOSPITAL: 1 YES 2 NO 1 Metient 2 ER/Outpetient 3 DOA 4 Nursing Noma 5 Residence 8 Other (Specify) | | | | | | | | | | | |
| ву Рн | 27. MANNER OF DEATN 28a. DATE OF INJURY (Morith, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 YES 2 NO 28d. DESCRIBE NOW INJURY OCCURED | | | | | | | | | | | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | 281. LOCATION (Street City or Town, State) | N (Street and Number or Rural Route Number, wn, State) | | | | | | | | | |
| COMPLETED | 29a. CERTIFFIER (Check only one) CERTIFFING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner as stated. Description of the basis of examination end/or investigation, in my opinion, death occurred at the time, data and piece, end due to the cause(s) and manner as stated. | | | | | | | | | | | |
| | 200 SIGNATURE ANTITULE DE CERTACIER | | | | | | | | | | | |
| TO BE | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA | | 1.D. | D 22 | D 2 2 5 49 | | | | | | | |
| | | | | e 2600 Rive | male, Marvil | fres | 20737 | | | | | |
| | 31. DATE FILED (Month, Day, Year) JAN 251996 July Drugger Parks Signal State of Months of Signal State of Signal | TURE | as mile | 2000 10100 | zane, itilyi | CA SA | 20101 | | | | | |
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| OR ATTENDING PHY DIRECTOR: After this hours after death wit | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR STATE REGISTRAR | | STATE OF I | MARYLA | | | | EALTH AND I | MENTA | L HYGIENI REG. NO. | E | | | | |
|------------------|---|---|-------------------------------------|---|----------------------------|-----------------------------------|---------------------------|--------------------|---------------|-----------------------------|----------------|------------------------------|-----------------|---|--|
| | 1. DECEDENT'S NAME (First | , Middle, Last) | CERTIFICATE OF DEATH | | | | | | | E OF DEATH 3. TIME OF DEATH | | | | | |
| | WALTER | F | EDWARD | | | SWAN | Ţ | | Ton. | | | YEAR | 1:30 |) D M | |
| : | 4. SOCIAL SECURITY NUMBER | | 5. SEX 8. AGE (In yrs. last birthd) | | | | | | | January 28, 199 | | | PLACE (State of | | |
| į | 215-26-6311 | | 1X M 2 🗆 F | 67 YRS. MONTHS DAYS HOURS M | | | | | Nov | 7, Day, Year) 7 22, 1 | MD | | | | |
| - | Be. FACILITY NAME (If not in | | | | | | | R LOCATION OF DE | EATH | | EATN | | | | |
| 2 | Memorial | | ital | | | | Cumber | .and | | | Al | lega | iny | | |
| ני | 10a. STATE | ON | 10- | | | | | CITY | | | | | | | |
| FUNERAL DIRECTOR | WV | Mir | neral | | Ridgeley | | | | | | LIMITS? | | | | |
| 4 | 10e. STREET AND NUMBER | | | _ | | 101. ZIP CODE | | | | | 10g. CITI | ZEN OF Y | VHAT COUNTR | Υ? | |
| H H | Route 2 Box 524 26753 USA | | | | | | | | | | | | | | |
| 5 | 11. MARITAL STATUS | U.S. ARMEI | D | | | 17 (Specify Yea | — American | Indian, | | | | | | | |
| | 1 Never Married 2 X | | IF YES, GIVE V | FORCES? 1 YES 2 NO It yes, specify Cuban, Mexican, Puarto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: | | | | | | | | Black, White, atc. Specify: | | | |
| B | 3 Widowed 4 Divo | orced | 1 | | | | | 21 | | white | | | | | |
| COMPLETED | 15. DEC (Specify on | EDENT'S EDU | CATION completed) | | (Give I | DENT'S USU | . KIND OF BUS | INESS/IND | | | | | | | |
| 4 | Elementary/Secondary (| 0-12) | College (1-4 or 5 | +) | ille. Do NOT use retired.) | | | | | | | | | | |
| N N | 12 | | | | Construction Worker | | | | | Construction | | | | | |
| 3 | 17. FATHER'S NAME (First, M | fiddle, Last) | | | | 18. MOTHER'S NAME (First, Middle, | | | | | | | | | |
| BE | George | | an | | | | Nora (Ryan) | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (| Type/Print) | | | 19b, M | IAILING ADD | RESS (Street a | nd Number or Rural | Ploute Num | ber, City or Town | n, State, Zip | Code) | | | |
| - 1 | Barbara A | | 1 | | Ro | ute 2 | Box 5 | 24: Ride | relev | , WV | 2675 | 3 | | | |
| | 20a. METNOD OF DISPOSIT 1X Burial 2 □ Crematic | ION on 3 - Rem | noval trom State | | | | SPOSITION (Ne | me of | DAT | | CATION — | | | | |
| | 4 Donation 5 Other | 1X Burisi 2 Cremation 3 Removal trom State 4 Donation 5 Other (Specify) Fort Ashby Cemetery 02/01 Fort Ashby, WV | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | | |
| | Scarpelli Funeral Home Cymberland MD 21502 | | | | | | | | | | | | | | |
| | 23. PART I/Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | | | |
| | / shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| | disease or condition Franchitic and | | | | | | | | | | | | | | |
| H | resulting in death) | | | | | | onic b | LOHCHILLI | .5 411 | u | | | - | | |
| , | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): Emphysema with Pneumonia 2 Weeks Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | |
| HIFICATION | CAUSE (Disease or Injury that Initiated avents DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| Ŧ | resulting in death) LAS | ST | d. | | | | | | | | | | | | |
| 5 | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I, 24s, WAS AN AUTOPSY 24b, WERE A | | | | | | | | | | | | | // | |
| Ä | PART II. Othar aignitica | ant condition | ma contributing to | death bu | it not rasi | ulting in tr | ia undariying | cause given in | Part I. | PERFOR | MED? | 248 | AWAILABLE PR | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? | |
| MEDIC | | | | | | | | | | 1 YES 2 | NO | | OF DEATN? | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES AND UNCERTAIN | | | | | | | | | | 1 YES 2 | □ NO | | | |
| ż I | | | RIBUTE TO CA | | | | | UNCERTAI | N \square | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED 1 EXAMINER? | TO MEDICAL | HOSPITAL: | 2 | 26. PLACE C | | heck only one) HER: | | | | | | | | |
| 2 | 1 TYES 2 NO | | 1 Minpetiant 2 | | | DOA 4 | Nursing Hom | e 5 🗆 Raeldenca | | | | | | | |
| E | 27. MANNER OF DEATH | Danding | 26a. DATE Of (Month, I | | - 2 | 86. TIME OF INJURY | WO | RK7 | 26d, DE | SCRIBE NOW I | NJURY OC | CURED | | | |
| E E | 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be 4 Nomicide detarmined 2 Description 26a. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 28a. PLACE OF INJURY — At home, larm, street, factory, office City or Yown, Stafe) 28t. LOCATION (Street and Number or Rural Research City or Yown, Stafe) | | | | | | | | | | | | | | |
| 3 | | | | | | | | | Poute Number, | | | | | | |
| COMPLET | 29a. CERTIFIER | TIEVING BUYE | SICIAN: To the best o | mu ba | adaa diise | | the steel state | and alexander | do th | unada) 4 | | ad. | | | |
| M | onel - | | | | | | | | | | | | a) and manner | as stated | |
| 3 | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) | | | | | | | | | | s) area markey | as stated. | | | |
| n n | 29b. SIGNATURE AND TITLE | | 29c, LICENSE NUN | | | | ABER 29d. DATE SIGNED (MC | | | | fear) | | | | |
| 2 | | | D 18769 | | | | | 130/96 | | | | | | | |
| | 30. NAME AND ADDRESS O | | | | | | | | 0150 | 0 | | • | į, | | |
| | | s Rave | r Memor | ial H | lospi | tal | Cumber | land,MD | 2150 | 2 | | | | | |
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DIVISION OF VITAL HECCHUS, F.C. BOX 2010.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR |
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| 1 - | STATE |

| REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. NO. | | |
|--|--|--|-------------------------|---|---|------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| GLADYS M | AXINE | SEE | | | JANUARY 2 | 7 1996 | 11:45 A M |
| 4. SOCIAL SECURITY NUMBER 5. | SEX 6. AG | | F UNDER t YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | IPLACE (State or Foreign |
| 236-36-1439 | □ M 2 □XF | 68 YRS. | ONTHS DAYS | HOURS MIN. | | | perland, N |
| De. FACILITY NAME (If not institution, give street | and number) | | | OR LOCATION OF DE | | 9c. COUNTY OF D | EATH |
| Sacret Heart Hos | pital | | Cumbe | rland | | Allega | ny |
| 6a. STATE 10b. COUNTY | | | TOWN OR LOCA | | | | 10d. INSIDE CITY LIMITS? |
| WV Hardy | 1 | Mod | refie | ld | | | 1 TES 2XXHO |
| HC 70 Box 21 | | | 11 | 26836 | | 10g. CITIZEN OF United | States |
| 11. MARITAL STATUS 12 1 Never Merried 2 Married 3 Never Merried 4 Divorced | . WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 XNO | If yes, s | CENDENT OF HISPAN pecify Cuban, Maxica S 2 NO Specify | | Spec | E — American Indian, k, White, atc. |
| 15. DECEDENT'S EDUCATI (Specify only highest grade con | ON Wieted) | 16e. DECEDENT'S US | SUAL OCCUPAT | ION | 16b. KIND OF BUS | INESS/INDUSTRY | |
| Elementary/Secondary (0-12) | college (1-4 or 5+) | life. Do NOT use | retired.) | iosi or working | | | |
| 12th | | Cook | | | Schoo. | l Syste | m |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | WE (First, Middle, Maiden | Surname) | |
| Ora Lester Heavi | ner | | | Lelia | Whetzel | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | loute Number, City or Town | | |
| Barbara Swick | | HC 70 | Box | 37, Moo | refield, | WV 268 | 36 |
| 20e. METHOD OF DISPOSITION 1.X. Burlai 2 Cremation 3 C Removal | from State | ob. PLACE AND DATE OF cometery, crematory or other | DISPOSITION (for place) | lame of | | CATION — City or To | |
| Donation 5 Other (Specify) | | cemetery, cremetory or other Co | meter | .y | 1/30 Mo | orefiel | d, WV |
| 21. SIGNATURE OF FUNERAL SERVICE LICENS | Omohe |) | Eln 217 | nore-Cha lunches | mbers Ful ter Ave. | neral H | ome |
| 23. PART I. Enter the diseases, or com | plicetions that caus | ed the death. Do no | | | | | Approximate |
| shock, or heert feliure. List IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) a | Rest | i sach line. | 7 le | arlin | re | | Interval Between Onset and Daati |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | CUND M DUE TO (OR A QUO Q | S A CONSEQUENCE OF: | nto | neus Ric Ric | moning lenfe hter's | rug Syrdon | >67ea |
| 11 130 | mà- | Hro | и 60 с | ytope 1 | Part I. 24s. WAS AN PERFOR | MED? | D. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| DID TOBACCO USE CONTRIB | SUTE TO CAUSE | | | | 101 | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | OSPITAL: | | OTHER: | me 5 🗆 Residence | 8 Other (Specify) | | |
| 27. MANNER OF DEATH 1 A Natural 5 Pending | 28s. DATE OF INJUR (Month, Day, Yes | Y 28b. TIME | OF 28c. If | JURY AT PORK? YES 2 NO | 28d. DESCRIBE HOW II | NJURY OCCURED | |
| 2 Accident Investigation 3 Suicide 6 Could not be | 28s. PLACE OF INJU- building, etc. (S | JRY — At home, ferm, str Specify) | | | 281. LOCATION (Street a City or Town, State) | and Number or Rural | Route Number, |
| 29e. CERTIFIER CERTIFYING PHYSICIA | N: To the best of my kr | owledge, death occurred | at the time. de | te and place, and due | to the cause(s) and mar | nner as stated. | |
| and and | | | | | | | a) and manner as stated. |
| 29b, SIGNATURE AND TITLE OF CERTIFIED | Celia | Le (1 8) | M-D | 29c. LICENSE NUI | 7516 | | (Month, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON THIS C | OMPLETED CAUSE OF | DEATH (ITEM 27) (Type, F | Print) | Drive C | und hards | JANUA | 21502 |
| 31. DATE FILED (FOUR Day, Yearly | (1/4.1) | IGNATURE O | CTUTI | 11166 | unweria | na, ru | 21506 |



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DIVISION OF VITAL RECORDS, P.O. BOX 68/6u

To the Hospital DR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

To the FONEARA DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burlat, cremating, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| STATE | 0F | MARYLAND | / DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIEN | N |
|-------|----|----------|--------------|----|--------|-----|---------------|---------|----|
| | | C | ERTIFICATE | 01 | F DEAT | TH | | REG. NO | Э. |

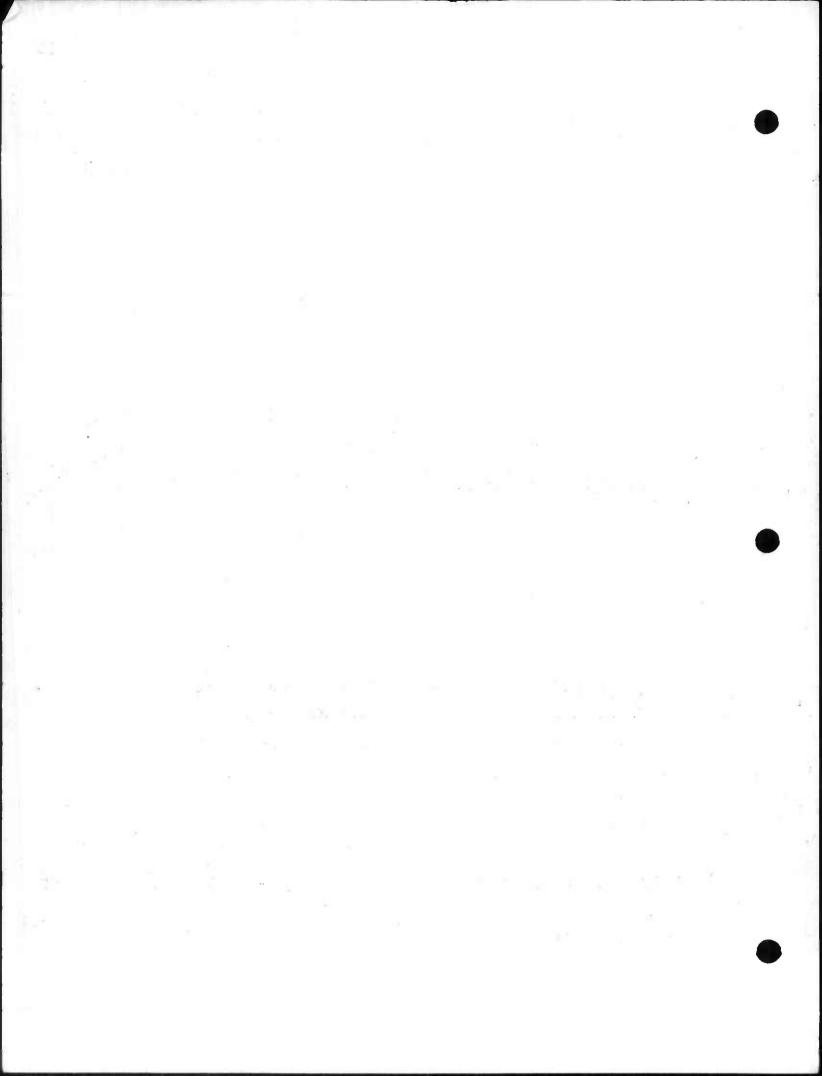
| FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | ENTAL HYGIEN | _ | |
|--|--|--|---------------------|---|--|---------------------|--|
| t. DECEDENT'S NAME (First, Middle, Last) | | 0 | | | 2. DATE OF OEATH | | 3. TIME OF DEATH |
| OGDEN | LEROY | SUE | NFR. | | JANIIARY 2 | NAY YEAR 29 1996 | 04:50 |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| In yrs. last birthday) IF | UNDER 1 YEAR | | 7. DATE OF BIRTH | a. BIRT | HPLACE (State or Foreign |
| 217-14-448 9a. FACILITY NAME (If not institution, give s | 1 € M 2 □ F 72 | YRS. | NTHS DAYE | R LOCATION OF DEA | July 8, 1 | 923 Mary | yland |
| Sacred Heart Hosp | | | Cumber1 | | | Allegany | |
| RESIDENCE OF DECEDENT | Tear | | Jamborr | | | | |
| 10e. STATE 10b. COUNTY | | | OWN OR LOCAT | ION | | | tod. INSIDE CITY LIMITS? |
| Pennsylvania Bedfo | rd | Bedi | ford | ZIP CODE | | 10g, CITIZEN OF | 1 YES 2 NO |
| Rd#3 Box 209 | | | 1 | 5522 | | U.S.A. | |
| 11. MARITAL STATUS t Never Married 2 Married 3 気 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 TYPE YES IF YES, GIVE WAR OR DO | 2 NO | If yee, spe | ENOENT OF HISPANI icity Cuben, Mexican, 2 NO Specify: | C ORIGIN? (Specify Ye Puerto Rican, etc.) | Ble | CE — American Indian, ck, White, atc. ch/White |
| 15. OECEDENT'S EDU (Specify only highest grade | | 16e. DECEDENT'S US (Give kind of work | UAL OCCUPATIO | N et of weeking | 16b. KIND OF BU | ISINESS/INDUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Machine (| Hired.) | | V011v-S | nringfie | ld Tire Co. |
| 17. FATHER'S NAME (First, Middle, Lest) | | nachine (| Speraco | | E (First, Middle, Maider | | ra Trie CO. |
| Homer Geiger | Suder | | | Edith | | Jenkin | 0.00 |
| 19e. INFORMANT'S NAME (Type/Print) | 5555 | 19b. MAILING AD | DRESS (Street e | | oute Number, City or Tox | | |
| Linda Simons | | | | | alley, Pe | | ia 15522 |
| 20e. METHOD OF OISPOSITION 1 Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | oval from State | PLACE AND DATE OF C | n/ecol | | 1 | DIATION — City or 1 | Town, State d, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | | isethemor. | 22. NAME AN | D ADDRESS OF FAC | LITY | | i, ii ar y raina |
| · Jenney | Kay M | ent | | | Funeral H reet. Cum | | 21502 Maryland |
| 23, PART I. Unter the diseases, or | complications that cause | the death. Do not | | | | | Approximate |
| immediate cause (Final | List only one cause on e | ach iine. | 11 | , _ | | | Interval Between Onset and Death |
| disease or condition resulting in death) | - ENDSTAG | Sp ///e | bartant | 7c 2011 | Amoul | Cell | 6 mos |
| resolving in destily | DUE TO (OR AS | CONSEQUENCE OF | 4 100 | 3.1 | ma of | . / | 2,1,00 |
| Sequentially flat conditions, | b | | (| Medine | ma of | Lyny | |
| If any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | 0 | |
| CAUSE (Diseese or injury | C. OUF TO (OR AS (| CONSEQUENCE OF: | | | | | |
| thet initieted events resulting in death) LAST | 502 10 (011 10 1 | CONSESSENCE OF J. | | | | | j |
| | d | - | | | - | | |
| PART ii. Other eignificent condition | e contributing to death b | out not resulting in t | the underlying | ceuse given in F | Part I. 24a. WAS AI | N AUTOPSY 24 | Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| - $COFD$ | | | | | 1 _ YES | 2 7 NO | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | 1 YES 2 NO |
| DID TOBACCO USE CONT | RIBUTE TO CAUSE C | F DEATH YES | | UNCERTAIN | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HQ9PITAL: | 28. PLACE OF DEATH | THER: | | | | |
| 1 TYES 2 NO | 1 Inpetlant 2 ER/Out | | | e 5 🗆 Rasidenca (| Other (Specify) | | |
| 27. MANNER OF DEATH 1 Dentural 5 Pending | (Month, Day, Year) | 28b. TIME O | Y WO | RK? | 28d. DESCRIBE HOW | INJURY OCCURED | |
| 2 Accident Investigation | | | | ES 2 NO | | | |
| 3 Suicide 8 Could not be 4 Homicide determined | building, atc. (Spe | / — At home, farm, atre | et, fectory, offici | • | 28f. LOCATION (Street City or Town, State | | I Route Number, |
| 29a. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of my know | riedge, death occurred | it the time date | and place, and due t | o the councils) and ma | eriner as stated | |
| one) — | ER: On The basis of examination | | | | | | e(s) and manner as stated. |
| 290. SIGNATURE AND PITLE OF CERTIFIE | | | | 29c. LICENSE NUM | | | D (Month, Day, Year) |
| 9301 | 100001 | 21 mm | , | 77 | 1181 | > TAX | 29 199 |
| 30 MAME AND ADDRESS OF PERSON WI | O COMPLETED CAUSE OF DE | ATHY(ITEM 27) (Type, Pri | int) | has | 10 | JANU | ARY - JIII |
| Gary Wagone | (BD. 925 | Bishop (| Valsh | Koad/ | umberlar | nd MD | 21502 |
| JAN 3" V 1996 | St. L. CONTROL | N. C. C. | | | | | |

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| | FOR STATE REGISTRAR | STATE OF MARYLAN | ND / DEPARTM | | | | HYGIENE REG. NO. | | | | |
|------------------|---|--|--|---------------------|-------------------------------------|-----------------|---------------------|--------------|----------------------|--------------------------|------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | DEATH | | 3. | TIME OF DEATN | |
| | I ORFTTA F | 7 | SMICK | | | MONTH Lanuar | DAY | 1996 | EAR 6 · | 10 A. | м |
| | | | yrs. last birthday) III | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | 8. | BIRTHPLA | CE (State or Fore | ign |
| | 220-28-9201 9e. FACILITY NAME (W not institution, give stree | | 81 YRS. | DAYS DAYS | HOURS MIN. | | 17, | 1914 | Country) | WV | _ |
| DIRECTOR | Memorial Hospital & | | | Cumber1 | | AIN | | Alleg | | | |
| E C | 10a. STATE 10b. COUNTY | | 10c. CITY, T | TOWN OR LOCAT | ION | | - | | 10 | d. INSIDE CITY | |
| E | MD All | .egany | C | umberla | ha | | | | 11 | LIMITS? | |
| | 10e. STREET AND NUMBER | cquiry | | - Y | ZIP CODE | | | 10g. CITIZEN | OF WHA | T COUNTRY? | |
| FUNERAL | 1530 D Old Town | o Manor | | | 21502 | | - | US | A | | |
| S | | 2. WAS DECEDENT EVER IN U | J.S. ARMED | | ENDENT OF HISPAN | | | | RACE - | American Indian | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO ES | If yes, spe | city Cuban, Mexican 2 TO Specify | | en, etc.) | | Black, W Specify: | hita, etc. | |
| ВУ | 3 Widowed 4 Divorced | | | | -Λ | | | | | white | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade col | TION 1 (mpleted) | 6a. DECEDENT'S US (Give kind of work | k done during mo: | | 16b. Ki | ND OF BUS | NESS/INDUS | TRY | | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use n | etired.) | | | | | | | _ |
| MP | 12 | | Homem | aker | | | | Home | | | |
| 8 | 17. FATNER'S NAME (First, Middle, Last) | | | | 16. MOTNER'S NA | ME (First, Mide | dle, Malden S | iumeme) | | | |
| BE | George Edward | 1_Root_ | - | | - | a (Wh | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural F | | | | | -00 | |
| | Villa Hunt | | | | Street; | 7- | | | | 502 | |
| | 20a. NETNOD OF DISPOSITION 1 Duriel 2 Cremation 3 Remove | | LACE AND DATE OF LETT. CONTROL OF LETT. TABO | | | 01/2 | | ation — ch | | | |
| | 4 Donation 5 Other (Specify) | | Mt. Tabo | | | | | | 11, 11 | | - |
| | 0. 7 | 1 | 10 | Sca | o address of fairpelli E | unera | 1 Hom | e | | | |
| | Janes T | XIcarpel | h | | berland, | | | | | | |
| | 23. PART . Enter the diseases, or cor ahock, or heart failure. Lis | nplications that caused to account only one cause on eac | the death. Do not | enter the mo | de of dying, sucl | h ss cardis | c or respir | atory arrea | , | Approximat | |
| | IMMEDIATE CAUSE (Finei | | | | | | | | | Onset and | |
| | disease or condition resulting in death) a. | Acute Cere | bral Infa | arction | | | | | | 8 Days | 5 |
| | | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | | | | | |
| NO | Sequentially liet conditions, b. | D445 TO 400 AS A 6 | | | | | | | | | |
| Ē | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A C | ONSECUENCE OF): | | | | | | | | |
| 일 | CAUSE (Diseese or Injury C. | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | | | | <u> </u> | |
| CERTIFICATION | that initiated eventa resulting in death) LAST | | | | | | | | | | - 1 |
| 빙 | | | | | | | | | | | |
| A | PART ii. Other algnificant conditions | contributing to death but | t not reaulting in | the underlying | ceuse given in | Part I. 2 | 4s. WAS AN A | | | RE AUTOPSY FIN | |
| 음 | Hypertension | | | | | 1 | YES 2 | -ing | | MPLETION OF CA DEATH? | USE |
| ME | Coronary Arter | | | | | | | | 1 { | YES 2 NO | |
| ž | DID TOBACCO USE CONTRI | | | | UNCERTAIL | N 🗆 | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 406PITAL: | 8. PLACE OF DEATH | (Check only one) | | | | | | | |
| YS | | inpetient 2 ER/Outpet | lent 3 DOA 4 | ☐ Nursing Nom | e 5 🗌 Residence | _ | | | | | |
| | 27. MANNER OF DEATN 1 Natural 5 Pending | (Month, Day, Year) | 286. TIME (| SA MO | RK? | 28d. DESCF | NOH BBIF | JURY OCCUP | ED | | |
| BY | 2 Accident Investigation | 00- 01-05-05-01-05-0 | | | res 2 NO | and the same | | | | | |
| G | 3 Suicide 8 Could not be 4 Homicide datermined | 28s. PLACE OF INJURY — building, etc. (Specify | | eet, rectory, ornic | • | | Town, State) | nd Number or | Hurai Hour | e Number, | |
| COMPLET | 29a. CERTIFIER | | | | | | | | | | |
| MPI | (Check only | AN: To the best of my knowled | | | | | | | | | |
| <u>ō</u> | | On the basis of examination of | end/or investigation, | in my opinion, d | eath occured at the | time, data an | nd placs, and | due to the c | ause(s) ar | nd manner as ste | ted. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | ./ | \cap | | 29c. LICENSE NUI | MBER | | 29d. DATE S | IGNED (M | onth, Day, Year) | |
| 0 | 14 lusti as | 1 Hours | 1/ | | n 14865 | | | JAI | V 24 | 4, 1991 | 0 |
| | 30. NAME AND ADDRESS OF PERSON WHO | | 7 | | | | | | | | |
| | Dr. Barrera, Memo | rial Hospita | 1 Medica | 1 Ruild | ing Cumb | erlan | d, MD | 21 | 502 | | |
| | JAN 2 5 1996 | 37 DEGISTRAR'S SIGNAT | Rawfall | | | | | | | | |

•

| | | NEGISTRAN | | C | ENTIFICA | ALE OF | DEATH | HEG. N | 0. | | |
|--|---------------|---|---------------------------|------------------------------------|------------------------------------|-----------------|---|---|----------------------|-------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATN |
| | | Jane Lucas | Snyder | | | | | Jan. 6 | , 199 | 6 | 6:35 am |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | | UNDER 1 YEAR | - | 7. DATE OF BIRTH | | 8. BIRTH Count | IPLACE (State or Foreign |
| - | | 212-38-5635 | 1 M 2 XF | 95 | YRS. MON | THE DAYS | HOURS MIN. | Mov. 11 | ,1900 | Ma | ryland |
| pinous | | 9a. FACILITY NAME (If not institution, give | street and number) | Center | 9b. | CITY, TOWN | OR LOCATION OF DE | | | NTY OF D | |
| 65 | OR | Annapolis Nurs | ing & R | ehabil: | ition | Ann | apolis | | Anne | ο λι | cundel |
| ÷. | DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | IMIIII | C A | under |
| 300 | 2 | | Arunde | 1 | Arno | | ATION | | | | 10d. INSIDE CITY V LIMITS? |
| Į. | | | | | 11111 | | | | | | 1 TYES 2 NO |
| T per | RA | 1250 Seminole | Drive | | | 1 | or. ZIP CODE 21012 | | | USA | VHAT COUNTRY? |
| 020 physician. burial-transit permit, Pages 1, 2, | FUNERAL | 11. MARITAL STATUS | | | | | | | | | |
| 20 hysici urial- | 5 | 1 Never Married 2 Married | FORCES? | T EVER IN U.S. AF | MED NO | | CENDENT OF NISPAT specify, Cuban, Maxica | ilC ORIGIN? (Specify ' in, Puerto Ricen, atc.) | Yea or No- | 14. RACE Black | - American Indian, c, White, etc. ny: White |
| 21215-0020 I or attending physician. for use as the burial-fran | BY | 3 🕅 Widowed 4 🗌 Divorced | IF YES, GIVE Y | WAR OR DATES | | 1 🗆 YE | S 2 4NO Specifi | y- | 175 | Spec | w. White |
| 15-0(trending as the | ED | 15. DECEDENT'S ED | JCATION | 18a, DE | CEDENT'S USU | AL OCCUPAT | ION | 16b. KIND OF E | HISIMESS/IND | HETOV | |
| or att | | (Specify only highest grad | College (1-4 or 5 | (G | ive kind of work of Do NOT use ret | done during n | nost of working | TODA KIND OF C | JOSINE GO/IND | OUTH | |
| | COMPLET | | 4 | | eache | | | Coun | ty Sa | hoo | l System |
| AN the hos detach | 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTNER'S NA | ME (First, Middle, Meid | | 1100 | T DAPCEIII |
| | ш | George Lucas | 5 | | | | Marga | ret (Wa | lker) | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | 8 | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING ADD | RESS (Street | | Route Number, City or 7 | | Code) | |
| (f) as | 임 | Jean Ann Donol | ue | | 1250c | Semi | nole Dr | ive, Ar | nold. | MD | 21012 |
| RE, nay be page | | 20s. METHOD OF DISPOSITION | | 20b PLACE | AND DATE OF DE | SPOSITION // | Verne of | DATE 20c | OCATION | City or To | ern State |
| Page 6 may all director, page in must b | | 1-12 Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify) | noval from State | FROS | majory or other p | Memo | rial Pa | rk 1/10 | Fros | thu | ra. MD |
| ALTIMORE, death. Page 6 may be therefor, page | | 21. SIGNATURE OF FUNERAL CERVICE L | CENSEE | /IAA | | 22. NAME / | AND ADDRESS OF FA | CILITY Kight | Funer | al H | ome |
| ALTIN death. Pag e funeral di | | > (N) Whar | _XX | AH | | 309-3 | 311 Decat | ur St., C | umberl | and | MD 21502 |
| en - 9 m | | 23. PART i. Enter the diseases, or | complications the | t colleged the de | eth Do not a | | | | | | |
| in in | | snock, or heart failure. | List only one car | on each line |). | mier the m | ode of dying, auc | n wa cardiac or rei | piratory arr | est, | Approximata interval Between |
| | | iMMEDIATE CAUSE (Final disease or condition | D. | 0 0 | 0 - | 0 | • | 10 | | 1 | Onset and Death |
| ompletely fill or cremation. | | resulting in death) | a. DUE TO | (OR AS A CONSE | OLIENCE OF: | idi | o my or | arvy | | Wo | my years |
| P 0 0 7 0 | _ | | - X/ | 7 | 160 | / 0 7 8 5 | , 0 | <u></u> | | | , , |
| OX 68 te be execut sician and o orior to buri traumatic | CERTIFICATION | Sequentially list conditions, | b. DUE TO | (OR AS A CONSE | DUENCE OF): | UN | reomper | price | | | " |
| BOX cate be es hysician a prior to | ¥ | If any, leading to immediate cause. Enter UNDERLYING | . 11 | Wester | an | 166 | | | | | |
| P P P | Ē | CAUSE (Disease or Injury that Initiated evants | DUE TO | (OR AS A CONSE | DUENCE OF): | | | | | | |
| , P.O. I eath certific attending ph ntal Hyglene y, or other | F | resulting in death) LAST | d. | | | | | | | | |
| OS, Poe death the atten Mental the sijury, or | | DART II ON THE INTERNATION OF THE | | | | | | | | - | |
| T and and | EDICAL | PART II. Other significant condition | ne contributing to | death but not i | asulting in th | e undarlyi | ng cause givan in | | AN AUTOPSY ORMED? | 24b | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| | ä | tranction of | re to or | doge | and c | woo | nie | 1 YE\$ | 2 X NO | | OF DEATH? |
| OT - | Σ | | ression | | | | | | | | 1 YES 2 NO |
| | ä | DID TOBACCO USE | CONTRIBUTE | TO CAUS | SE OF D | EATH ' | YES NO | | | | |
| 一年 皇帝 5 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | CT | 26. I HER: | PLACE OF DEATH (Ch | ock only one) | | | |
| E VIT, SICIAN: The certificate on the State | YS | 1 TES 2 NO | 1 Inpatient 2 | | □ DOA 4 Ø | Nursing Ho | me 5 Rasidence | 8 Other (Specify) | | | |
| NG PHYSICIAN: Ther this certific eath with the St marked, or It | PHY | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF (Month, D | INJURY Pay, Year) | 286. TIME OF INJURY | ·W | IJURY AT ORK? | 28d. DESCRIBE HOV | V INJURY OCC | URED | |
| ON DING P After the death of the mark | BY | 2 Accident Investigation | | | | | YES 2 NO | | | | |
| | | 3 Suicide 8 Could not be 4 Homicide determined | 28a. PLACE C building, | F INJURY — At ho atc. (Specify) | me, farm, street | , factory, offi | ica | 281. LOCATION (Stree City or Town, Sta | et end Number (e) | or Rurel F | loute Number, |
| OIVISI OR ATTEN DIRECTOR: hours after Item 28 i | | | | | | | | | | | |
| 로 그 다 보 | 릴 | | | | | | | to the cause(s) and n | | | |
| HOSPITAL FUNERAL WITHIN 72 | COMPLETED | one) 2 MEDICAL EXAMIN | ER: On the basis of a | xamination and/or | Investigation, In | my opinion, | death occured at the | time, data and place, | and due to th | e cause(s |) and manner as stated. |
| THE HO Filed with | | 296. SIGNATURE AND TITLE OF CERTIFIE | R / | - 1 | 4) | | 29c. LICENSE NUI | ABER O | 29d. DATE | SIGNED | (Month, Day, Year) |
| TO THE HOSPIT TO THE FUNERA DE filed within 7 |) BE | (harles W. | Kins | ~ N | 10 | | D05 | 928 | D.T. | an | 7, 1996 |
| 3 | 2 | 30. NAME AND ADDRESS OF PERSON W | O COMPLETED CAU | SE OF DEATH (ITE | M 27) (Type, Print | ") | | | | | |
| IN 1 | | Charles Kinzer. | M. D. 20 | 003 Medi | cal Par | kwav | s/ 100 | Annapoli | S. MD | 21/4 | 11 |
| 1000 | | JAN 2 5 1996 | 3. PEGISTRY | R'S SIGNATURE | 1 11 | | -/ .001 | | O 2 1/11/ | 217 | |
| | [| JAN 2 9 1990 | your an | 从中国省的代刊的 省 | FEAT | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| INSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. It is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Let be be be a state of the action of the traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR | 99. FACIL WASH PRESIDE 10e. STAT 10e. STRE 133 11. MARIT 1 Nev 3 Wid Eleme 17. FATHE RIC 19e. INFO DAV. 1 M Burt |
|---|---|---|
| TO THE HOSPITAL DRINTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION | 23. PAR IMMEDI disease resultin Sequent if any, ic cause. I CAUSE that init resultin PART II. DID 25. WAS 0 EXAM 1 |

| 1 - BEGISTRAR | STATE OF MARYL | CERTIF | RTMENT OF | | MENTAL HYGIEN REG. NO. | | |
|---|---|----------------------------------|-----------------------|--|---|---------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | nda-Juneve | SPE. | Spessor | 5 | 2. DATE OF DEATH DATE OF TAN 2 | 7 199 | 3. TIME OF DEATH 6 0600 M |
| | 5 · · · · · · · | (in yrs. last birthday) 14 YRS. | MONTHS DAYS | | 7. DATE OF BIRTH (Morith, Day, Year) JUNE 2. 1 | | BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give stree | 77 | 14 | 9b. CITY, TOWN | OR LOCATION OF DE | | 9c. COUNTY | Maryland of DEATH |
| Washington County | Hospital | | Hage | rstown | | Wash | ington |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOC | ATION | | | 10d. INSIDE CITY |
| Maryland Washi | naton | Sn | nithsbw | ra | | | t VES 2 X NO |
| 10e. STREET AND NUMBER | | | | IOI. ZIP CODE | | 10g. CITIZEI | OF WHAT COUNTRY? |
| 13354 Greensburg R | | | | 21783 | | - | .S.A. |
| 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced | P. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 VNO | If yes, | ECENDENT OF HISPAN specify Cuban, Maxica ES 2 NO Specify | | s or No 14 | . RACE — American Indian, Black, White, etc. Specify: |
| 15. DECEDENT'S EDUCAT (Specify only highest grade cor | | 16e. DECEDENT'S (Give kind of | work done dudna i | TION nost of working | 16b, KIND OF BUS | SINESS/INDUS | TRY |
| Elementary/Secondary (0-t2) | College (1-4 or 5+) | Tell | | | Ban | h | |
| 17. FATHER'S NAME (First, Middle, Last) | | <u> </u> | Let | 16. MOTHER'S NA | ME (First, Middle, Maiden | | |
| Richard L. Kline | | | | Ravern | a L. Winte | rs | |
| 19e. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | |
| David A. Spessard | | 1335 | | | d Smithsb | | D 21783 y or Town, State |
| 1 M Burtel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify) | from State | netery, crematory or o | other place) | al Park | 1/30/96 | | town, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE | cauc Earl | | | | | |
| - Dreunlas A | / Fun | / | | | | | dbwry Ave. a. MD 21783 |
| 23. PART I. Enter the diseases or con shock, or heart fellure. Lis | fplicationa that csuse t only one cause on e | d the death. Do | not enter the n | node of dying, suc | h ss cardisc or resp | Iratory srres | Intervsi Batween |
| iMMEDIATE CAUSE (Final disesse or condition resulting in desth) | CARD | iomy | OPA | THY- | | | Onset and Death |
| | (AJZ) | CONSEQUENCE D | 20,00 | ATMM. | ARRES | , | 6 |
| Sequantisily list conditions, if any, leading to immediate | DUE TO (OR AS | CONSEQUENCE O | P | 11011 | 171010.22 | <u> </u> | |
| CAUSE (Disease or injury | | | | 17171011 | ATHY - | | |
| that initiated events resulting in death) LAST | OUE TO HOR AS | CONSEQUENCE O | MC | MITUS | · | | |
| d | 17775 | | | | | | + |
| PART II. Other significent conditions of | contributing to deeth b | out not resulting | In the underly | Ing ceuse given in | Part i. 24a. WAS AN PERFOI | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| DID TOBACCO USE CONTRIL | SUITE TO CAUSE O | DE DEATH V | ES TI NO | UNCERTAI | NI | | 1 TYES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | BOIL TO CAUSE C | 26. PLACE OF DEA | | | | | |
| | OSPITAL: | petient 3 🗆 DOA | OTHER: 4 Nursing H | ome 5 Raeldence | 8 Other (Specify) | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIR | ME OF 28c. I | NJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCCU | RED |
| 1 Netural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | |
| 3 Suicide 8 Could not be determined | building, etc. (Spe | r — Al home, ferm, cify) | street, fectory, of | fice | 281. LOCATION (Street City or Town, State) | | Rural Route Number, |
| Conservation | N: To the best of my know | | | | | | cause(e) and manner as stated. |
| 29b SIGNATURE AND TITLE OF CERTIFIED | Words | 5721 | no | 29c. LICENSE NU | NBER 2043 | 29d. DATE S | LIZZISG |
| 30. NAME AND ADDRESS OF MERSON WHO O | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type | OGRS! | TMO | 2179 | 10 | |
| JAN 2 9 1996 | REGSTRAR GIGH | LATURE | | | | | |

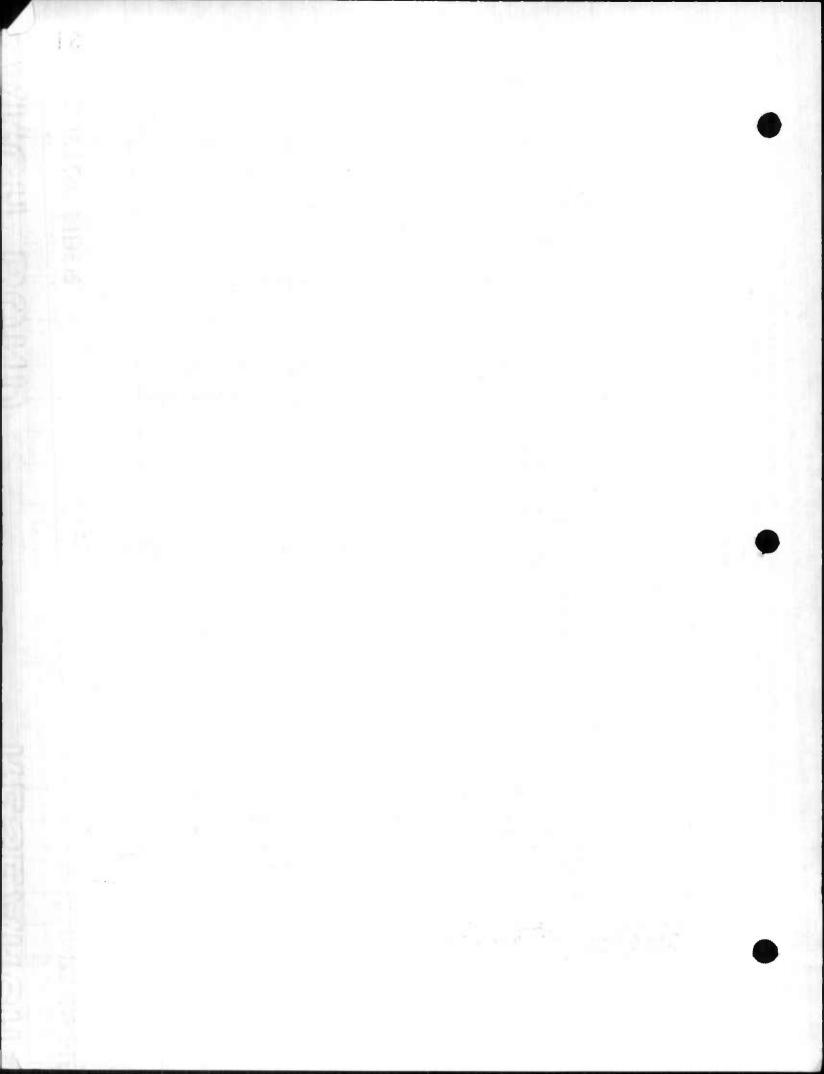
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and received within the feath. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral direction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) PRESTON AME | | NDERS | | | | | | 2. DATE OF DI MONTH Januar | DAY | 5,19 | YEAR | 10:30 P. |
|------------------|--|--|--|---|--|--|--|--|--|--|---|------------------------------------|--|
| - | 4. SOCIAL SECURITY NUMBER | 5, SEX | B. AGE (In yrs. | lest birthdev) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BU | RTH | | | LACE (State or Foreign |
| | 214-09-8920 | 1 🔀 M 2 🗆 F | 88 | YRS. | MONTHS | DAYS | HOURS | MIN. | June 2 | 21 1 | 907 | Country) | sylvania |
| _ 1 | 9a. FACILITY NAME (If not institution, give | street and number) | | | 96. CIT | r, TOWN | OR LOCATI | ON OF DE | ATH | | 9c. COU | NTY OF DE | ATN |
| FUNERAL DIRECTOR | Coffman Nursing | y Home | | | На | gers | stown | l . | | | Was | hingt | ton |
| | 10e. STATE 10b. COUNT | TY | | 10c. Cf1 | ry, TOWN | OR LOCA | TION | | | | | | 10d. INSIDE CITY |
| | | Washingto | n | | Smi | thsl | | | | | | | LIMITS? |
| 11 | 10e. STREET AND NUMBER | | | | | 10 | 1. ZIP COD | E | | | 10g. CITI | IZEN OF WI | HAT COUNTRY? |
| | 11920 Seminole D | rive | | | | | 217 | 83 | | | | U.S.A | 1. |
| | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | | NT EVER IN U.S. 1 YES 2 [WAR OR DATES | | | If yes, sp | CENDENT Code | n, Mexica | IIC ORIGIN? (Spo n, Puerto Rican, | etc.) | or No- | Black, Specify | - American Indian, White, etc. |
| I | 15. OECEDENT'S ED (Specify only highest grad | | 16a. | DECEDENT'S | work done | during mo | ON ost of working | na | 16b. KIND | OF BUSI | INESS/INC | DUSTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 8 | +) | IIIe. Do NOT u | ise retired.) | | | | | | | | |
| ŀ | 9 | 0 | | Bak | ter | | | | | Bak | - | | |
| | 17. FATNER'S NAME (First, Middle, Last) | | | | | | 1 | | ME (First, Middle, | | , | | |
| - | Lehman Sanders | | | | | | | | Kate Sl | | - | _ | |
| | 19e. INFORMANT'S NAME (Type/Print) | | | | | | | | Route Number, Cit | | | | 17/0 |
| 1 | Gordon Sanders | | | 17706 | | | | IVE | Hager | _ | | | |
| | 20a. METHOD OF OISPOSITION 1 Solution 2 Cremation 3 Res 4 Donation 5 Other (Specify) | | 20b. PLAC | crematory or a | ther place | mori | lal G | | n 1-29 | -96 | Hag | | own, Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE L | n | 4 - | , | 22. | NAME A | ND ADDRE | SS OF FA | CHUTY Mi | nnic | h Fu | neral | Home |
| ı | > Sast | 21 1/11 | nne | | | 15 7 | 7.7.4 | 1 | D 1 1 | - | | di di Shara | Md. 2174 |
| | 23. PART I. Enter the diseases, or ahock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) | complications the | at coused the | daeth. Do | | | oda of dy | ing, suci | | or respir | ratory an | | Approximate interval Betw |
| | abock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events | a | at coused the | SEQUENCE C | not enter | | oda of dy | ing, suci | h ee cerdisc o | or respir | ratory an | | Approximate interval Betw |
| | shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST | b. DUE TO d. | at caused the use on each ! | SEQUENCE O | not enter | The mo | le le le le le le le le le le le le le l | ing, suci | dist | lov (| ratory and | real, | Approximate interval Betwoon Onast and D |
| | abock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events | b. DUE TO d. | at caused the use on each ! | SEQUENCE O | not enter | The mo | le le le le le le le le le le le le le l | ing, suci | Part I. 24a. | or respir | AUTOPSY | 24b. | Approximate interval Betw Onaet and D 20 4/ |
| | shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST | b. DUE TO d. | at caused the use on each ! | SEQUENCE O | not enter | The mo | le le le le le le le le le le le le le l | ing, suci | Part I. 24a. | COV. | AUTOPSY MED? | 24b. | Approximate interval Betwoon on the interval Betwoon o |
| | shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST | b. DUE TO d. | at caused the use on each ! | SEQUENCE O | not enter | The mo | le le le le le le le le le le le le le l | ing, suci | Part I. 24a. | WAS AN A PERFORE | AUTOPSY MED? | 240. | Approximate interval Betw Onaet and D 30 4// |
| | shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST PART II. Other algnificant condition | b. DUE TO d. | at caused the use on each ! | SEQUENCE O | not enter | The mo | da of dy | eul | Part I. 24a. | WAS AN A PERFORE | AUTOPSY MED? | 240. | Approximate interval Betw Onaet and D 30 40/ |
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| | shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST PART II. Other algnificant condition SEQUENCE OF THE SECOND SECO | b. DUE TO d. One contributing to | of OR AS A CONTROL OF | deeth. Do line. SEQUENCE C SEQUENCE C | not enter | The mo | da of dy | given in | Part I. 24a. | WAS AN A PERFORI | AUTOPSY MED? | 240. | Approximate Interval Betw Onaet and D 30 4/1/ |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the conditions of the condition | b. DUE TO d. HOSPITAL: 1 Inpetient 2 28e. DATE Of (Month, 4) | of OR AS A CON | death. Do Ine. SEQUENCE C SEQUENCE C SEQUENCE C OT resulting | not enter | nderlyin 28. Ph | da of dy | given in | Part I. 24a. | WAS AN / PERFORI | AUTOPSY MED? | 24b. | Approximate interval Betw Onaet and D 30 40/ |
| | shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 JAN 27. MANNER OF DEATN | b. DUE TO d. DUE TO d. HOSPITAL: 1 Inpetient 2 28e. PLACE 0 | of the part of the | deeth. Do Ine. SEQUENCE C SEQUENCE C SEQUENCE C SEQUENCE C SEQUENCE C | In the under the officers of the sure of t | 1 the modern of | exce of course of the state of | given in | Part I. 24a. 1 cock only one) | WAS AN A PERFORE YES 2 City) E HOW IN | AUTOPSY MED? | 24b. | Approximate Interval Betw Onaet and D 30 Jul / S 10 Jul |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in deeth) LAST PART II. Other algnificant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending investigation 3 Suicide a Could not be determined. | b. DUE TO d. DUE TO d. HOSPITAL: 1 Inpatient 2 28e. PLACE building SICIAN: To the best of | of Control | deeth. Do Ine. SEQUENCE C SEQUENCE C SEQUENCE C SEQUENCE C A THE SEQUENCE C A THE SEQUENCE C A A A A A A A A A A A A A A A A A A A | In the unstreet, factored at the | 1 Less Parallel Paral | exce of course of the state of | given in | Part I. 24a. 1 □ sck only one) 8 □ Other (Spe 28d. DESCRIBI 28f. LOCATION City or Row to the cause(a) | WAS AN A PERFORB YES 2 city) E HOW IN I (Street arm, State) | AUTOPSY MED? NO AUTOPSY MED? NO AUTOPSY MED? | 24b. 1 CUREO CUREO r or Rural Ro | Approximate interval Betw Onaet and D 20 4/1 WERE AUTOPSY FIND! WARLABLE PRIOR TO COMPLETION OF CAURO OF DEATH? 1 YES 2 NO |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in deeth) LAST PART II. Other algnificant conditions. 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide a Could not be determined. 29a. CERTIFIER (Check only) | b. DUE TO d. DUE TO d. DUE TO d. PLACE (| of Control | deeth. Do Ine. SEQUENCE C SEQUENCE C SEQUENCE C SEQUENCE C A THE SEQUENCE C A THE SEQUENCE C A A A A A A A A A A A A A A A A A A A | In the unstreet, factored at the | 1 Less Parallel Paral | oda of dy Lice of course of the second of t | given in BEATH (Chi Beath (C | Part I. 24a. 1 Describer (Special Describer To The Carron | WAS AN A PERFORB YES 2 city) E HOW IN I (Street arm, State) | AUTOPSY MED? NO Number of Number as ste's didus to the | CUREO CUREO r or Rural Ro | Approximate interval Betw Onaet and D 20 4/1 WERE AUTOPSY FIND! WARLABLE PRIOR TO COMPLETION OF CAURO OF DEATH? 1 YES 2 NO |
| L | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST PART II. Other algnificant conditions in the initisted events resulting in death) LAST 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 VES 2 MO 27. MANNER OF DEATN 1 Netural 5 Pending investigation Pe | b. DUE TO d. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE | DE ER/Outpatient F INJURY Dey, Year) OF INJURY At a Consultation and a consultation and | death. Do Ine. SEQUENCE C SEQUENCE C At resulting 28b. Till N home, ferm, death occur for investigati | In the under the street, factor, in my | 1 Less Parallel Paral | oda of dy Lice of course of the second of t | given in | Part I. 24a. 1 Describer (Special Describer To The Carron | WAS AN A PERFORB YES 2 city) E HOW IN I (Street arm, State) | AUTOPSY MED? NO Number of Number as ste's didus to the | CUREO CUREO r or Rural Ro | Approximate interval Betw Onaet and D 30 40/ |



Please Type or Print in Black Indelible ink. Assure All Copies Are Logible

State of Maryland / Department of Health and Mental Hygien 9 6

Certificate of Death

| esting. | Physician /Medical |
|---------|-----------------------|
| | Examiner |

1. Decedant's Name (First, Middle, Last)

Month

2. Data of Death

Day

3. Tima of Death

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantal Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

You the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Medical Certification:

Division of Vital Records, P.O. Box 68760,

| al | 10/11/20 | JATA | 5 | o cre | | | | | | Jan | d/ | 199 | 16 | 10:30 |
|---------------------------|---|--|--------------------|---|------------------------|--------------------|-------------------|-------------------|-----------|----------------------------------|------------|-------------|---------------------------|---|
| er | 4a. Facility Nama (If | not institution, gh | e street and num | nber) | | | - | 4b. City, To | wn, or L | ocation of Deat | th 4c. | County of | Death | |
| | WASHIN | GTON CO | UNTY H | OSPITA | ٩L | | | HAG | ERST | TOWN | | WASH | INGT | ON |
| | 5. Social Security Nu 217-30-7 | ımber 6. S | | 7. Aga (In yrs. 59 | |) If Und Months | ar 1 Yaar Days | If Undar Hours | | 8. Date of Bi Month, D | irth | 0 | | (State or Foreign |
| | Usual Rasidance of | | | | | | | | | 11111 | , 10 | 001 | | .,,,,, |
| tor | 10a. Stata MARYLAND | 10b. County WASHING | GTON | | y, Town or L SERSTO | | | | | | | | | Inside City Limits 1 🎗 Yas 2 🗆 No |
| 9 | 10e. Street and Num | bar | | | | 10f. Z | lp Coda | | | | 10a. Citiz | zen of Whi | t Country? | |
| Ö | 201 ROSS S | | APT. A | | | | 21740 | 1 | | | | J. S. | | |
| 'e | 201 NU33 3 | DINEE! | AFI. A | | | | 21/40 | , | | | | J. J. | ۸. | |
| Funeral Director | 11. Marital Status 1 ☐ Never Marrie | d 2 Married | Armed For | 21 No | S. 13. | If Yas, sp | ecify Cub | an, Maxica | n, Puarto | pecify Yas or No Rican, etc.) | 0- | | American I Whita, atc. | ndian, |
| þ | 3X Widowad 4 | Divorced | If Yas, Give | a itas: | | 1 🗆 Yas | 2LXNo | Specify: | | | | Specify: | WHIT | E |
| Completed by | - | 15 Decedent's E | duaction | | 16a Dage | edent's Us | iai Ossur | ntlon | | | 16h Kir | nd of Busin | nass/Indust | m4 |
| iet | (Special | Decedent's E fy only highest gri | ade completed) | | (Give | e kind of w | ork done | during mos d) | t of work | king | TOD. Kill | nd or busit | iass/iridust | y |
| du | Elamantary/Secon | idary (0-12) | College (1- | -4or 5+) | | | | a) | | | | 01411 | | |
| Ö | 11 | | | | HU | MEMA | KER | | | | | OWN | HOME | |
| Be | 17. Fathar's Nama (/ | First, Middle, Last |) | | | | | 18. Moth | ar's Nam | a (First, Middle | e, Maiden | Sumame) | | |
| 8 | ROY L | EE R | CE | | | | | ED | ΝΔ | ELIZ | ARET | Н | SUMM | IFRS |
| 2 | | | | | | | | | | | | | | |
| | 19a. Informant's Na | | | | | _ | | | | rai Route Numi | - | | | de) |
| | BRENDA | L. REP | , | | 542 | EURG | E 511 | KEEI, | HAG | ERSTOWN | I, MD | . 21/ | 40 | |
| | 20a. Mathod of Dispo | osition | | 20b. P | laca of Disp | osition (N | eme of | COV | | Date | 20c. Lo | cation - Ch | y or Town, | Stata |
| | | Cremation 3 C 5 Othar (Special | | ROS ROS | emetery, cre SE HIL | L CEI | METER | RY | 01+3 | 31-96 | HAGE | ERSTO! | WN, M | ARYLAND |
| | 21. Signature of Fun | aral Sarvice Lica | nsaa | , | 2 | 2 Name | and Addre | ss of Eacili | YAAL I | FUNERAL | LIOME | TAL | 0 | |
| | D. P | 6-1 | Sun | 111 | | | | | | | | | | 10 |
| | 7 -70, | 1 week | - Corece | ey, | 4 | U E. | ANII | LETAM | SI. | , HAGER | STUWN | I, MD | . 21/ | 40 |
| | 23a. Part1. Entar the shock, or haart Immadiata Causa (F | | ona causa on | lina. | n. Do not ar | itar tha mo | oda of dyli | ng, such as | cardiac | or respiretory | errest, | | On | proximate erval Between sat and Death |
| | disaasa or condition rasulting in daath) | | a. ANTER | 1050000 | 0770 | Hor | ar b | 15=1 | rF | | | | 54 | STEATE YAS |
| _ | radaking wir datatily | | | Due to (o | r es e conse | quenca of |): | | | | | | | |
| hysician/Medical Examiner | | | And a | 111 11 Take | | 1.100 | £ 500 | | | | | | 1 | 43100 |
| Ē | Coguantially list con | ditions | b. AMA | | es e conse | | | | | | | | | |
| EX | Saquantially list con if any, laading to Imr cause. Enter Undar Causa (Disaase or Ir | nadieta | | Dau 10 (0) | 00 0 001100 | I GOOTING OF | ,. | | | | | | | |
| Ö | Causa (Disaase or Ir | njury | C | | | | | _ | | | | | | |
| 음 | that initiated avants rasulting in daath) La | | | Dua to (or | as a conse | quence of |): | | | | | | | |
| N N | | | | | | | | | | | | | i | |
| 2 | | | d | | | | | | | | | | 1 | |
| 0 | Dod II Other classific | and and distance | | - A - | felt of the Africa | | | | 4 | l ook Did | l dah sasa | | A 1 - A - A - A - A | cause of death? |
| ys | Part II. Other signific | cant conditions t | contributing to de | ath but not rast | Jiting in that | undanying | causa gr | en in Part | I. | | | | - | |
| 듄 | C 444 41 4 1 1 1 | | 1000 | PULMO | a horas . | 41 . | | | | 10 | Yes 2 | □ No 3 | Probabl | y 4 Unknown |
| by | CHRONIC | 003777 | 14100 | , 00,40 | on ny | W. | (6713 E | | | | | | | |
| X | | | | | | | | | | | s an autop | sy | 24b. Were | utopsy findings |
| ete | | | | | | | | | | pen | lormed? | | comple | ole prior to ation of cause |
| ğ | ==== | | | | | | | | | | | | of deat | h? |
| 0 | | | | | | | | | | 10 | Yes 2 | 9 No | 1 □ Yé | es 2 No |
| Be Completed by P | 25. Was casa refarre | ad to medical | | | | | | 20 Dia - | and Date | | | | | |
| | examinar? | _ | Hospital: | | | | Ott | or: | | th (Check only | | | | |
| L | 1 ☐ Yas 2 ☐ ↑ | 10 | 1 U Ir | · | ER/Outpatie | | JOA | 4 LI N | ursing H | oma 5 Ras | | | | |
| Ë | 27. Mannar of Death | E □ Bondino | 26a. Data o | f Injury h, Dey Year) | 28b. Tima o Injury | of | 28c. Injui Wol | rk? | | 28d. Dascribe | how Injury | y occurred | | |
| atic | 1 Netural 2 Accident | 5 Panding Investigatio | | 125 | n ijur y | M | | Yes 2 | No | | | | | |
| Sertification: | 3 Suicide | 6 Could not b | | of injury - At ho | ma farm e | traat facto | ry office | | | 28f. Location | (Street an | d Number | or Rural Re | oute Number |
| Ę | 4 🗆 Homicide | determined | buildin | of injury - At ho ig, atc. (Specify | /) | aai, rault | .y, omos | | | City or To | wn, State |) | | |
| 8 | | | 1 | | | | | | | | | | | |

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

101040

DA, HAGERSUWY MB, 21772

29d. Date signed (Month, Day, Year)

01-29-56

State Registrar

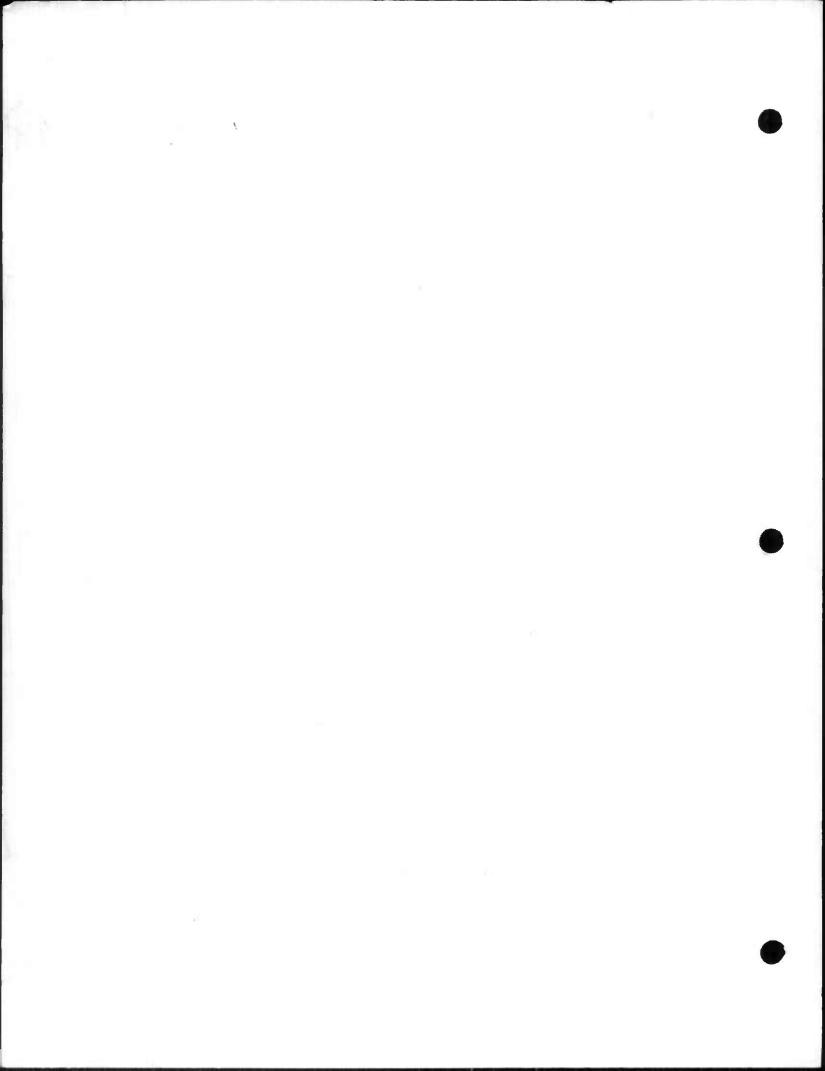
29a. Cartifian

29b. Signatura and titia of certifiar



30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

| | | REGISTRAN | | CERTIF | ICATE OF | DEATH | F | REG/NO. | | | |
|---|------------|--|--|--|------------------------|---|---------------------------------------|-----------------------------------|----------------------------------|----------------------------------|--|
| | | 1. OECEDENT'S NAME (First, Middle, Last) | MANNA MAE | STOCK | SLAGER SI O | ier | 2. DATE OF MONTH | 129/9 | YEAR | 3. TIME OF DEATH | |
| P | | 4. SOCIAL SECURITY NUMBER 215-42-3657 | 5. SEX 6. AGE (| (In yrs. last birthday) 55 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, De SEPT | BIRTH / 1940 L, 1940 | Country) | ARYLAND | |
| pinods | - | Sa. FACILITY NAME (If not institution, give a | - Control | | 9b. CITY, TOWN | OR LOCATION OF C | EATH | 9c. CO | UNTY OF OE | ATN | |
| . 2, 3 | DIRECTOR | WASHINGTON COUNT | Y HOSPITAL | | | HAGERSTO | WN | | WASH | HINGTON | |
| Pages 1, | JEC | 10a. STATE 10b. COUNTY | 1 | 10c. CIT | TY, TOWN OR LOCA | ATION | | | 7 | 10d. INSIDE CITY | |
| .≓. & | | MARYLAND | WASHINGTON | | FUNK | STOWN | | | | LIMITS? | |
| permit. | IAL | 10e. STREET AND NUMBER | | | 10 | Of. ZIP COOE | | 10g. Cl | TIZEN OF WI | HAT COUNTRY? | |
| an. ransit | NER | 8 EAST BALTIMOR | | | | 2173 | | | U. | S.A. | |
| 215-0020 attending physician. use as the burial-transit | BY FUN | 11. MARITAL STATUS 1 Never Married 2 X Merried 3 Divorced 4 Divorced | 12. WAS OECEOENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR O | 2 NO | If yes, s | CENOENT OF NISPA pecify Cuban, Mexic S 2 X NO Speci | en, Puerto Rica | pecify Yes or No— n, etc.) | 14. RACE - Black, Specify: | | |
| 215-0 attending se as the | 8 | 15. OECEOENT'S EOU | | 16a. OECEOENT'S | USUAL OCCUPAT | ION | 16h KH | IO OF BUSINESS/IN | IDUSTRY | WHITE | |
| T 8 2 | | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give kind of life, Do NOT u | work done during m | ost of working | I I I I I I I I I I I I I I I I I I I | O O DOGINESS/IN | DOSTRI | | |
| 0 5 8 | 실 | 9 | | | HOMEMAK | ER | | OWN I | HOME | | |
| de the | COMPL | 17. FATNER'S NAME (First, Middle, Last) | | | | 16. MOTNER'S N | AME (First, Midd | le, Malden Surname) | | | |
| R P P P P P P P P P P P P P P P P P P P | 6 m | LEWIS McCOY | | | MABEL HOFFMAN | | | | | | |
| MAR retained 5 should | 2 | 19a. INFORMANT'S NAME (Type/Print) | 3.000 | | | and Number or Rural | | | | | |
| m × g 4 | S | FRANK L. STOCKSL | | | | , FUNKSTY | | | 21734 | | |
| 6 m of 5 | | 20a, METHOO OF OISPOSITION 1 Surial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State cerr | PLACE AND OATE refery, cremetory or c JNKSTOWN | | | 1/96 | 20c. LOCATION - | | | |
| Page dire | | 21. SIGNATURE OF FUNERAL SERVICE LIG | | DIVINDIOVIA | - | NO AOORESS OF FA | KCILITY | | | ARYLAND | |
| BALTIN after death. Pag y the funeral di noval. | | raw M.K | lan Paul | M. Dean | BAST | FUNERAL | HOWE: | 7606 Old Boonsbor | | onal Pike | |
| in the | | 23. PART I. Enter the disesses, or of shock, or heart failure. | omplications that caused List only one cause on e | the death. Do | not enter the m | ode of dying, suc | ch as cardiac | or respiratory as | rrest, | Approximata interval Between | |
| y filled ition, or | | IMMEDIATE CAUSE (Finsi disesse or condition | < . 1 | 0-1 | _ | /1. | | | | Onset and Death | |
| d within ompletely I, cremati | | resulting in death) | , sacral | CONSEQUENCE | comy | W1+1- | <u> </u> | | | 3 mont | |
| B76 uted v comp rial, c | | | (hand c | ROMEGOENCE | 1 1 | 1/1000 | | | | 11/0 | |
| X 6 | CATION | Sequentially list conditions, if any, leading to immediate | OUE TO (OR AS A | CONSEQUENCE O | INSEQUENCE OF): | | | | | year | |
| ate by arion prior | S | cause. Enter UNDERLYING CAUSE (Disesse or Injury | <u>. </u> | | | | | | | | |
| ing pl | RTIFIC | that initiated events resulting in death) LAST | OUE TO (OR AS A | CONSEQUENCE O | moll | 40 | 1 | 1-11 | ~ | 201 | |
| atten mtal H | ' I III II | | Nune | 65 / | ren r | ius, | 19 | be IT | | av years | |
| at the dea by the att | | PART II. Other significant condition | contributing to death b | ut not resulting | in the underlying | ig cause given in | Part I. 24 | . WAS AN AUTOPSY PERFORMED? | | WERE AUTOPSY FINDINGS | |
| O E DE | | | | | | | 1 | YES 2 NO | 0 | COMPLETION OF CAUSE OF CEATH? | |
| A required been sign for Head | Σ | | | | | 1 | | | 1 | YES 2 NO | |
| > All our | ¥ | DID TOBACCO USE CONTI | | F DEATH YI | | UNCERTAI | и 🗆 📗 | | | | |
| £ 2 2 | i i | EXAMINER? | HOSPITAL: | | OTHER: | | | | | | |
| HYSICIAN: The State with the State | : ≩ | 27. MANNER OF OEATN | 28e. OATE OF INJURY | 28b. T/N | E OF 28c. IN | ne 5 - Residence | | ecity) BE NOW INJURY OC | CCUREO | | |
| + | ВУ Р | 1 Netural 5 Pending Investigation | (Month, Day, Year) | IN. | JURY W | YES 2 NO | | | | | |
| TENDING ODE: After death | | 3 Suicide 6 Could not be | 26e. PLACE OF INJURY building, atc. (Spec | - At home, farm, | street, factory, offic | DO . | 28f. LOCATIO | N (Street and Numbe wn, State) | or Rural Roi | ute Number, | |
| DR ATTENE DIRECTOR: hours after | | 4 Homicide determined | | | | | City di ic | WII, SIERE) | | | |
| TAL DR A AL DIREC 72 hours | 3 | | CIAN: To the best of my knowl | | | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 is | COMPL | 2 MEDICAL EXAMINE | R: On the beals of examination | n and/or investigation | on, in my opinion, | death occured at the | tima, date and | place, and due to t | the cause(a) r | and manner as stated, | |
| THE H filed w | BE | 250 AND WILL OF CERTIFIER | america | Mn | | 294. LICENSE NUI | MINER | 296. DAT | re signes a | Aonth, (Rey, Walr) | |
| 5533 | 2 | wer en | 1 James | IND | | 1355 | 47 | | 1/29 | 7/96 | |
| | | 30 NAME AND ADDRESS OF PERSON WHO | LI ON VI | | , , | uite 7 | 08 | | 101 | Hegerston | |
| | | 31. OATE FUEDHINOUTH, DAY MAIN | 2 NASSIGNARISMON | Arunt . | no 1 | 1110 me | dical | capp pu. | 5 Ka | MD 2714 | |
| | | JAN 3 1 1996 / | Co. to enter Separation | KONG. | | | | | | | |



Please Type or Print in Biack Indelible ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 95

03851

| | | | | | , | Certificate of | | Re | g. No. | | ,000. |
|------------|---|----------------------------|--|---|---------------------|---|--|--|-----------------------------------|-----------------------------------|---|
| п | Physici | ian | 1. Decedent's Name (First, Middle, La | • | | | | 2. Dete of Deeth | | Year | 3. Tima of Deeth |
| | /Medi | | Ruth | Alice |) | Simmor | | Jan 24 | Day 199 | 6 | 10:25AM |
| | Examir | ner | 4a. Facility Nama (If not Institution, giv | e street and number) | | | 4b. City, Town, or I | ocation of Deeth | 4c. County | of Death | |
| L | | | The Memorial | Hospital | at Ea | aston | Easton It Under 24 Hrs. | 10 D / //Din | Talb | ot | |
| L | Funeral Director | | 5. Sociel Security Number 220-78-0139 Usuel Residence of Decedent | ex | (In yrs. last birti | rs. Months Deys | Hours Min. | 8. Dete of Birth (Month, Pay, NOV • 19 | 7960 | 9. Birthpl Count Balt | leca (State or Foreign |
| | Mand was | | 10a. Stete 10b. County | | 10c. City, Town | or Location | | | | 10 | 0d. Inside City Limits |
| | Man | to | MD. Caroli | ne | Pres: | ton | | | | | 1 ☐ Yes 2 No |
| | or 28 | irec | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of W | /het Count | try? |
| | th will | a D | 6218 Bethlehem | Road | | 216 | 55 | | U | SA | |
| 21215-0020 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanticer must be notified at | by Funeral Director | 11. Merital Stetus 1 Never Married 2 Merrled 3 Widowed 4 Divorced | 12. Wes Decedent Ev Armed Forcas? 1 Yes XXX It Yes, Give Yeer or Detes: | | 13. Was Decedent of I If Yas, specify Cub 1 ☐ Yes 2 ② No | | pecify Yas or No- o Rican, etc.) | Bleck | - Amarica k, White, e White | etc. |
| 2-0 | 72 ho | te | 15. Decedent's Ed | | 16a. | Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire | pation | tina 1 | 6b. Kind of Bu | siness/Ind | lustry |
| 21 | en " | Completed | (Specify only highest gra Eiementery/Secondery (0-12) | Collega (1-4or 5+ |) | | | | | | |
| 2 | wed w | 5 | 11 | 0 | | Custodia | - | | ducation | | |
| Maryland | 2 should be filled within n and Mental Hygiene. Is marked other than "raumatic event, the Way | To Be | 17. Father's Neme (First, Middle, Last, William Simm | | | | | eme (First, Middle, Maiden Sumame) e Ruth Neville | | | |
| lar | 2 sho | | 19e. Intormant's Neme/Reletionship (| | 19b. | Meiling Address (Street | t and Number or Ru | ıral Route Number, | City or Town, | State, Zip | Code) |
| | of Health Item 27 other tr | | John D. Simmon | S | 62 | 18 Bethle Disposition (Name of | hem Rd. | | | | |
| Baltimore, | permit. Pages 1 Department of H Important: If its any injury or ot once. | | 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | Ramovai from State | cemeter | crematory or other pla | ory Jan | | 6 D | | , Del. |
| Ball | Depart Import any in | | 21. Signature of Funaral Service Licer | | | Willian | nson Fur | ieral Ho | me | | |
| 3 | Physician /Medical Examiner | er | 23e. Pert1. Enter the disease, or com shock, or heert teilure. List only tmmediete Ceuse (Finet disease or condition resulting in deeth) | Aguires | ~ / | y unase | | | | ì | Approximete Interval Between Onset and Death |
| Box 68760, | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit | Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Last | C | | onsequence of): | | | | | |
| | be att | sici | Pert II. Other significant conditions of | ontributing to death but | not resulting In | the underlying ceuse gi | ven in Pert | 23b. Did tol | bacco use con | tributa to | the cause of death? |
| 0.9 | d by t | | Chroute ph | staruct | 11/0 |) Junear | V disea | 112 Ye | 8 2 No | 3 Prob | oably 4 Unknown |
| | w requires that been signed to should be det | by | 01001000 | 30 40 000 | 100 | Ultilogy / | y anca | | | 0.00 150 | entro a les autilités s |
| 0 | requi | etec | | | | | | 24e. Was ar parform | ned? | SVE | ere autopsy tindings eilable prior to mpletion ot cause |
| Records, | has t | Completed | | | | | | | | of c | death? |
| al | | | | | | | | 1□ Ye | s 20/No | 1 🗆 | Yes 2⊖No |
| Vital | Physician: rthis certificant and director, | Be c | 25. Was cese ratarred to medical examiner? | Hospitet: | | Ot | hor | ath (Check only one | | - 10 | |
| o | 는 문들 | 1: To | 1 ☐ Yes 2 ☑ No 27. Manner of Deeth | 1 ☑ Inpatien | | patient 3L DOA | 4 Li Nuising F | lome 5 Reside | | | " |
| O | ding Ph th. After th funeral | tior | 1 Neturel 5 ☐ Pending 2 ☐ Accident investigation | 28e. Date of Injury (Month, Day | Year) In | | ork?]Yes 2□No | | | | |
| Division | or Atterdes | Certification: | 3 Suicide 6 Could not b determined | 28e. Plece of tnjur building, etc. | | m, street, fectory, office | | 28f. Location (Str. City or Town | reet and Number, State) | er or Rura | l Route Number, |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical C | 29e. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Example 1 | yetctan: To the best of niner: On the basis of e end mannar state | xaminetion end | deeth occurred et the ti | ime, dete and place opinion, death occu | o, end due to the ce prred et the time, de | use(s) end me ite and piece, e | nner as st and due to | eted. the cause(s) |
| | Vithi To th | X | 29b. Signeture and title of certifier | Luco. | | 29c. Lican | sa number | 25 | d. Date signed | (Month, I | Day, Year) |
| | | | 30. Neme end wirass ot person who | completed cause of dea | eth (Item 23e) (| Type, Print) | 11/16 | | ' 00 | | * |
| | | | James Sides | 920 Mark | et Str | eet,Dento | on.MD 21 | 629 | | | |
| | Sta Registr | | 31. Deta tiled (Month, Day, Year) JAN 26 | 32. Registrar | 's Signature | | ess 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | M to V | | | |
| | | | | | | AL PORTO | | | | | |

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| DALIMONE, IN | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any hours after death. Page 6 may be re | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| DISCOUNT OF THE PERCENCY, T.O. DON GOING | 10 | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| | • | FOR STATE REGISTRAR | STATE OF M | | | | OF HE | | | MENTAL | HYGIEN REG. NO. | E | | |
|--|---------|--|-------------------------------|---------------------|---------------------------------------|----------------|--------------------------|---------------|----------|-----------------------------|--------------------|--------------|-----------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE O | D/ | W Y | EAR | 3. TIME OF DEATH |
| | ŀ | ROBERT THO 4. SOCIAL SECURITY NUMBER | OMAS 5. SEX | 6. AGE (In yrs. les | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS | JAN 7. DATE O | | 199 | | 7:20 AM M |
| | | 212-05-2909 | XXM 2 D F | 81 | YRS. | MONTHS | - | HOURS | MIN. | (Month, | Day, Year) | | Country) | YLAND |
| ~ | | Se. FACILITY NAME (If not institution, give str | | | | 9b. CITY | TOWN OF | LOCATIO | ON OF DE | | | 9c. COUNTY | | |
| E | | 117 PARRIS LAN | NE, APT | . н2 | | E | ASTO | N | | TALBOT | | | | OT |
| DIRECTOR | | 10a. STATE 10b. COUNTY | | | 10c. CIT | | OR LOCATIO | | | | | | | 10d. INSIDE CITY LIMITS? |
| | | MARYLAND TAI 100. STREET AND NUMBER | LBOT | | | E | ASTO | N ZIP CODE | | | | 10a CITIZEI | | Y YES 2 NO |
| FUNERAL | | 117 PARRIS LANE | E, APT. | Н2 | | | | 21 | 601 | | | | SA | |
| | ш | 11. MARITAL STATUS 1 □ Never Married 2 ★ Married | 12. WAS DECEDENT FORCES? 1 | YES 2 V | NO | 13. | WAS DECE | NDENT O | F HISPAN | NC ORIGIN? In, Puerto Ri | (Specify Yes | or No — 14 | RACE - | - American Indian, White, etc. |
| 8 | - 11 | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | _ _ | 1 TYES 2 | X NO | Specify | y: | | | Specify | WHITE |
| TED | | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | (G | CEDENT'S live kind of Do NOT us | work done | CCUPATION during most | of working | g | 16b. I | (IND OF BUS | SINESS/INDUS | TRY | |
| 1 2 | | Elementary/Secondary (0-12) | College (1-4 or 5+ | , | | | NAGE | D | | 7 | EROSI | ንአሮቱ | | |
| once. COMPLET | | 17. FATHER'S NAME (First, Middle, Last) | | | HELD | 1111 | - | | ER'S NA | | ddle, Maiden | | | |
| BE BE | | REV. THEODORE (| CHRISTIA | | | | | | | | STEIN | | _ | |
| TO BE | | RUTH Y. SORGE | | | | | | | | | | EAST | , | MD |
| ed te | I | 20e. METHOD OF DISPOSITION 1 Burlal 2 A Cremation 3 Remo | val from State | 20b. PLACE | AND DATE | OF DISPOS | ITION (Nam | e of | | DATE | 20c. LO | CATION — CIT | or Tow | n, State |
| or must | ŀ | 4 Donation 5 Other (Specify) | | SALT | SBUR | | | | | | | SBUR | | MD |
| medical examiner | ľ | MEN/a | - 211 | TII C | .6 9 | | | | | | | P.A | | |
| lical | 1 | 23. PART I. Enter the diseases, or co | omplications that | coused the de | eth. Do i | not enter | the mod | e of dyle | AKK. | TSON | ST., | EAS | LON | , MD Approximate |
| e me | | Shock, or heert fellure. L | lst only one ceu | se on each line | | | | | | | | | | Onset and Death |
| f, | I | resulting in death) | DUE TO | asta | tic | m | de | pre | int | me | lan | no | | 04-07-95 |
| or other traumatic event, the ERTIFICATION | | | DOE 10 (| OH AS A CONSE | OUENCE O | F): | | 4 | | | | | | |
| CATION | | Sequentially list conditions, if any, leading to immediate | DUE TO (| OR AS A CONSE | GUENCE O | F): | | | | | | | | |
| FI C | | CAUSE (Disesse or Injury that Initiated events | DUE TO (| OR AS A CONSE | DUENCE O | F): | | | | | | | | - |
| | 1 | resulting in death) LAST | | | | | | | | | | | | |
| y injury. | \ }: | PART il. Other significant conditions | contributing to | deeth but not r | esulting | in the un | derlying | csuse g | iven in | Part i. | 4a. WAS AN | | | YERE AUTOPSY FINDINGS |
| E S | ľ | | | | | | | | | _ | PERFOR | 1 | 0 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 2 ≥ | | DID TOBACCO USE CONTR | IDLITE TO CAL | ISE OF DEA | TU VI | · C 1 | 10 🗆 | LINIC | ERTAIN | | | | 1 | YES 2 NO |
| SICIAN: | | 25. WAS CASE REFERRED TO MEDICAL | | | E OF DEA | | | UNC | EKIAII | 4 LJ | | | L | |
| or item YSICI | | 1 VES 2 NO | HOSPITAL: 1 Inputient 2 | ER/Outpatient 3 | □ DOA | OTHER 4 Num | | 5 The | sidence | 6 Other | Specify) | | | |
| P. P. | | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF I | | 26b. TIM | E OF URY | 28c, INJUI | | l NO | 28d. DESC | RIBE HOW IN | JURY OCCUR | ED | |
| Is mar D BY | | 2 Accident Investigation 3 Suicide 6 Could not be | 26a. PLACE OF | INJURY — At ho | me, term, s | street, fact | | .9 4 | NO | | | nd Number or | Rural Roi | ute Number, |
| 티 | 1 | 4 Homicide determined | Dulloning, a | ine (Specify) | | | | | | City or | Town, State) | | | |
| IMPORTANT: If Item O BE COMPLE | | 29a. CERTIFIER (Check only one) | | | | | | | | | | | | |
| S | - | 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER | : On the basis of ex | emination and/or i | Investigatio | n, in my o | | | | | nd place, and | | | |
| MPOR BE | | | ever, | M.D. | | | | D 1 | | | | | | Nonth, Day, Year) 2 - 9 Ca |
| | - 11- | 36. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITE | M 27) (Type, | Print) | | | | | | | | |
| ≥ 2 | | | 1110 | and a - | | | - | | - | | _ | | | |
| ٦ | | Robert W. TRE | VER 32_REGISTRAN | T G TG | 0, | دوم | ne | Jak | eur | ay | , Ea | rote | 1 | Md.21601 |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

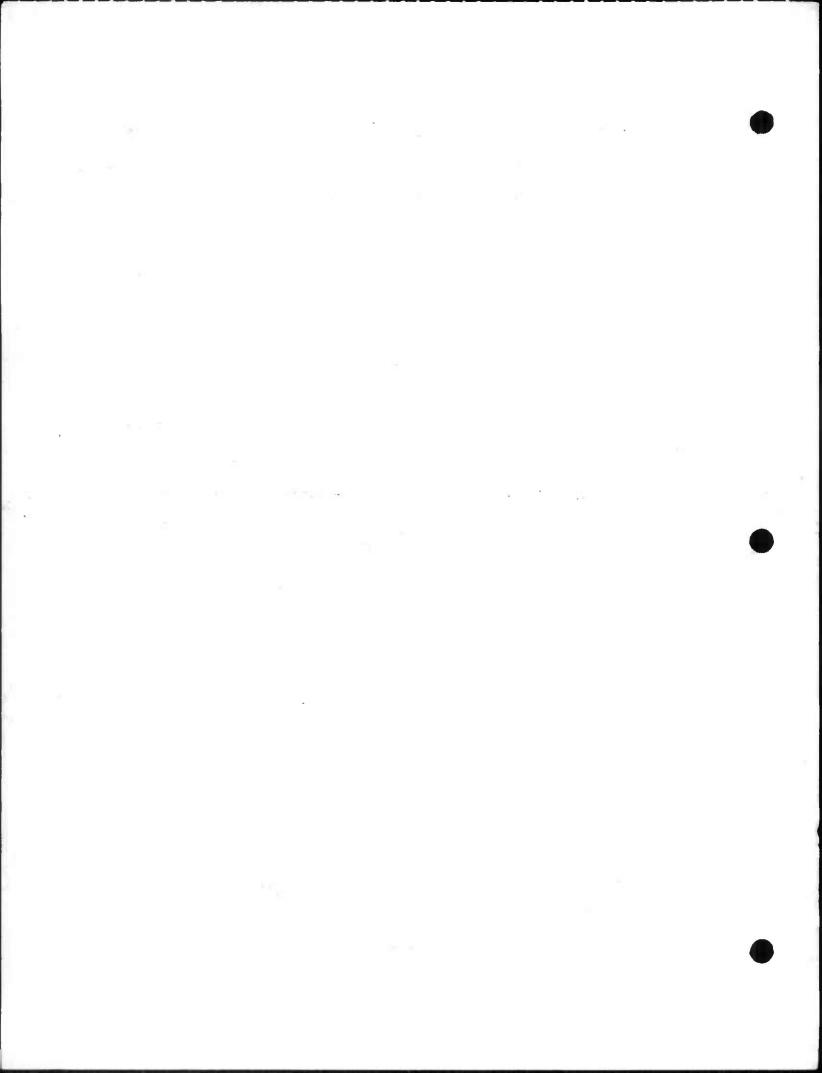
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 | | FOR STATE REGISTRAR | |
|---|---|---------------------------|--|
| П | - | DECEDENTIS NAME (| |

| | REGISTRAR | | CE | RTIFI | CATE OF | DEATH | | REG. NO | | | | |
|--|---|--|------------------------|-----------------------------------|------------------------|---|-------------|----------------------------------|-------------|-------------------|-----------------------------------|-------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | 2. DATE | OF DEATH | | | 3. TIME OF DEA | TH |
| - | DORSEY_ | | SMIT | H | | | JANU | ARY 2 | | 96 | 7:20 | Рм |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6 | 3. AGE (In yrs. lest t | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE C | OF BIRTH | | S. BIRTH | PLACE (State or I | Foreign |
| | 214-12-6957 | 1 M 2 - F | 83 | YAS. | MONTHS DAYS | HOURS MIN. | | 24, 1 | 912 | MARY | , | |
| | 9e. FACILITY NAME (If not institution, give : | street and number) | | | 96. CITY, TOWH | OR LOCATION OF D | | | | NTY OF DE | | |
| DIRECTOR | BERLIN NURSING & | REHABILITA | ATION CT | . | BERLIN | | | | | WORCESTER | | |
| H | 10a. STATE 10b. COUNT | Y | | 10c. CITY, | TOWN OR LOC | ATION | | | | | 10d. INSIDE CIT | Υ |
| | MARYLAND WORCE | STER | | WHA | LEYVIL | LE | | | | | 1 WES 2 | NO NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | 1 | Of, ZIP CODE | | | 10g. CITI | ZEN OF W | HAT COUNTRY? | |
| HI I | 8641 WHALEYVILLE | ROAD | | | 2: | 1872 | | | U | SA | | |
| 2 | 11. MARITAL STATUS | 12. WAS DECEDENT I | EVER IN U.S. ARMI | ED | 13. WAS DE | CENDENT OF HISPA pecify Cuban, Maxic | NIC ORIGIN | ? (Specify Yes | or No- | 14. RACE Black | - American Ind White, atc. | llan, |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | R OR DATES | | | S 2 NO Speci | | acan, etc.) | | Specif | | | |
| ED | | 15. DECEDENT'S EDUCATION 16a. DECEDEN | | | | | | The second second | | | MULTE | |
| | (Specify only highest grade | (G/ve | kind of wo | SUAL OCCUPAT ork done during n | iost of working | 16b. | KIND OF BUS | SINESS/IND | USTRY | | | |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | ONCUD | HOMY | NAT. | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | AKPE | NTER | 18. MOTHER'S NA | | CONSTR | | אנ | | |
| Ö | McFADDEN SMITH | | | | | LUCY JO | | nucie, marcen | Surneme) | | | |
| 00 | 19a. INFORMANT'S NAME (Type/Print) | | 196. | MAILING A | DDRESS (Street | and Number or Rural | | es Chu or Fran | n State 7in | Codel | | |
| 임 | EDITH M. SMITH | | | | | LLE RD., | | | | | 1072 | |
| | 20a. METHOD OF DISPOSITION | | | | DISPOSITION (| | DATE | | CATION - | | | |
| 1 | 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | ioval from Stata | DALE | CEME | er place) | | 1 | 9/96 | | | ILLE, 1 | · |
| ı | 21. SIGHATURE OF SOMERAL SERVICE LI | CENSEE | 1 2122 | · · | | AND ADDRESS OF FA | | . 70 70 | MILL | TIPI | Thur, I | ш. |
| | > /1/. U / | 120 V | | | | | | | | | | |
| \dashv | 22 BADT i Enter the diseases or | que | 0 | | HASTI | NGS FUNE | RAL HO | DME, S | ELBY | VILLI | | |
| | 23. PART i. Enter the diseases, or shock, or heert feliure. | LIST DRIV DRA CAUSA | nn aach line | | | | | | | | Approxin | A Acres and |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | Onset sn | d Death |
| | resulting in deeth) - a. a. May tage conjugation of 2 yes | | | | | | | | | | | rs |
| _ | IMMEDIATE CAUSE (Final disease or condition resulting in deeth) a. Due to (or as a consequence of): Sequentielly flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Pinal disease or conditions, or can be caused to the cause of the cause | | | | | | | | | | | |
| ō | Sequentielly flat conditiona, | Sequentielly ilat conditions, DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | use. | and | 2_ | į | |
| E | CAUSE (Disease or Injury that initieted eventa | | R AS A CONSEOU | | | | | | | | | |
| | resulting in deeth) LAST | d | | | | | | | | | | |
| | PART II. Other algnificant condition | a anatoliustan ta d | | 141 | | | | | | _ | | |
| EDICAL | Par de anglinicant condition | e. CV | / | | | A | Part i. | 24a. WAS AN PERFOR | | | WERE AUTOPSY I AVAILABLE PRIOF | TO |
| ă | Day and Market | - 4 | | m | ontes | 1 | | 1 YES 2 | X) NO | | COMPLETION OF OF DEATH? | CAUSE |
| Σ | Mass n | | ug; 10 | ran | n a | cropies | | | | | 1 TYES 2 X | NO |
| PHYSICIAN: | DID TOBACCO USE CONT | RIBUTE TO CAU | | | NO [| | N 🗆 | | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | - | | (Check only one OTHER: |) | | | | | | |
| 17S | 1 VES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 I E | | DOA 4 | Nursing Ho | ma 5 🗌 Raaldence | | | | | | |
| | 1 X Natural 5 Pending | 28a. DATE OF IN. (Month, Day, | Year) | INJU | RY W | JURY AT ORK? | 26d. DESC | CRIBE HOW I | NJURY OCC | URED | | |
| B | 2 Accident Investigation | 28 PLACE OF L | NJURY — At home | | | YES 2 NO | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | building, ato | c. (Specify) | r, ractri, ser | wer, ractory, om | Ca | City of | TION (Street a r Town, State) | ind Number | or Rural Ro | oute Number, | |
| 9 | 29a. CERTIFIER | | | | | | | | _ | _ | | |
| COMPLETE | (Check only | | | | | | | | | | | |
| One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as | | | | | | | | stated. | | | | |
| 8E | 296. SIGNATURE AND TITLE OF CERTIFIES | 1 01 | 00 | , (| 6 1) | 29c. LICENSE NUI | MBER | | | | Month, Day, Year, | |
| ē, | selgerio" | 14. 12 | ellos | 2) | not , | D29505 | | | > / | -2. | 5-96 | |
| 7 | 30. NAME AND ADDRESS OF PERSON WH | | | | | | | | | | | |
| | GREGORIO BELLOS | The second secon | | VOOD | PL CRI | SFIELD, I | MD 218 | 817 41 | 10–96 | 8-31 | 49 | |
| | 1AN 2.9 1996 | | | | | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Locible

ITEMS: 23 PART I, II, 27, State of Maryland / Department of He

| alth and Mental Hygiene | 9 | 6 | 0 | 3 | 8 | 5 | L |
|-------------------------|---|---|---|---|---|---|---|
| | | | | | | | |

| | | 1. Decedent's Nama (First, Middla, | Last) | | | ertificate (| | | 2. Data of D | Reg. Ne | 0. | | 3. Time of Death |
|--|-----------------|--|---|----------------------------|--|---|----------------------|-------------------------|--------------------------------------|---------------------------|-------------|-----------------------------|--|
| Physicia /Medic | | VIRGINIA | HOLLAI | ND | SHU | PE | | | Month JAN. | 22 | , 19 | Year 96 | 1000 At |
| Examine | er | 4a. Fecility Nama (If not institution, | | m <i>ber)</i> | | | | 4b. City, Town, or Loca | | cation of Death 4d | | of Death | |
| | | 8754 SHELL R | | | | | | LMAR | | | | MICC | |
| Funeral Director | | 214-32-0708 | 3. Sex 1 ☐ M 2 🖾 F | 7. Aga (In yrs | . last birthd Yrs | Months Di | | dar 24 Hrs. rs Min. | 8. Data of Bi (Month, D August | rth ay, Year 17, 19 | 35 | 9. Birthpl Count Mary | lace (Stata or Foreign try) I and |
| yand | | Usual Rasidance of Decedant 10a. Stata 10b. County | | 10c. C | ity, Town o | r Location | | | | | | 10 | 0d. inside City Limits |
| r 28a-f ahow | cto | Maryland Wico | mico | | De | elmar | | | | | | | 1 ☐ Yas 2 ☒ No |
| 5 3 | Director | 10e. Street and Number | | | | 10f. Zip Co | la | | | 10g. C | Itizen of W | /hat Count | try? |
| 23a | a | 8754 Shell Rd. | | | | 2 | 1875 | | | | USA | | |
| urs a | by Funeral | 11. Maritai Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Dec Armed Fo 1 Tas If Yas, Gi Yaar or D | va | J,S. | 3. Was Decedant if Yes, specity 0 | | | pecify Yas or N Rican, atc.) | 0- | | - Amarica k, Whita, a | |
| 2 no | ted | 15. Decedant's | Education | | 16a. De | cedent's Usuai O | cupation | nont of word | kina | 16b. I | Kind of Bu | sinass/Ind | lustry |
| then " | Completed | (Specify only highest Elamantary/Secondary (0-12) 1 2 | Collaga (| 1-4or 5+) | - lii | iva kind of work do a. DO NOT use re Homemake | | TOSE OF WOR | Cirig | I | Domestic | | |
| | Be C | 17. Fathar's Nama (First, Middle, La | ist) | | | | | other's Nam | e (First, Middle, Malden Suma | | | | |
| | 0 | John E | Wooten | | | | R | osell | e | В | adfo | rd | |
| od 2 sn lith and 27 is m | | 19a. Informant's Name/Ralationship James Shupe | (Type, Print) | | | alling Addrass (St 3754 Shel | | | | | | Stata, Zip | Code) |
| permit. Pages 1 and Department of Heat Important: If item 2: any Injury or other once. | | 20a. Mathod of Disposition 1 ⊠Burlai 2 □ Cramation 3 4 □ Cogation 5 □ Other (Spe 21. Signature of Funeral Service Life | Stata | cematary, | sposition (Nama of crematory or other 11 Memory 22. Name and Arthur Hollow | <i>place)</i> Gardens drass of Fa ay Fu | cility neral | | Н | ebror | City or Too | | |
| | | 23a. Part1. Entar the disaasa, or co shock, or haart failura. Liat or | omplications that | used tha daa | th. Do not | antar tha moda of | OW H1 dylng, such | as cardiac | ., Sali | Sbur arrest, | y,MD | 2180 | Approximata |
| hysician | 1 | shock, or hardrianula. Light of | | ALCOHOL INTOXICATION | | | | | | | | | intarval Between Onset and Death |
| /Medical Examiner | | immediata Causa (Final disease or condition rasulting in death) | tensolute Continue la | | | | | | 2 Ances | | | | |
| 44 24 15 | ě | rasulting in daath) | | Dua to (| or as a con | sequance of): | | | | | | | |
| al-transit | xamir | Sequentially list conditions, if any, laading to immadiate | b | Dua to (| or as a con | sequance of): | | | | | | | |
| nicate be executed ng physician and as the burial-transit | edical Examiner | Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last | C | Dua to (| or as a con | sequance of): | | | | | | | |
| attending p for use as | IN/Me | | d | | | | | | | | | | |
| the attended for u | Physician/M | Part ii. Other eignificant conditions | contributing to d | eath but not ras | sulting In th | a undarlying cause | givan in Pa | art i. | 23b. Did | tobacc | o use con | tribute to | the cause of death? |
| - X 10 | by Phy | ARTERIOSCLEROTIC | CARDIOVASO | CULAR DIS | EASE | | | | 1□ | Yee : | 2□ No | 3 Prob | ebly 4 Unknown |
| | Completed | | | | | | | | 24a. Wa | an auto | opsy | ava | ra autopsy findings illable prior to npletion of cause death? |
| page page | 000 | | | | | | | | 10 | Yes 2 | ≥ □ No | 1/2 | Yes 2 No |
| | | 25. Was casa rafarred to medical axaminar? | | | 26. Place of Death (Check only one) | | | | | | 1 | | |
| 20 | 0 | XXYes 2 No | | Inpatiant 2 | | | | Nursing H | oma XXRas | | | |) |
| th. : After t | ation: | 27. Mannar of Death 5 ☐ Pending | 28a. Data | of injury th, Day Year) | 28b. Tim | n of 28c. | njury at Work? | | 28d. Dascribe | how inju | ury occurre | ed | |

To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the f

6XXCould not be datamined

1 Certifying Phyeician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

XX Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and mannar stated. 29c. License number O.C.M.E

29d. Data signed (Month, Day, Year) JANUARY 23, 1996

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 8754 SHELL ROAD

DELMAR, MARYLAND

30. Nama and addrass of person who completed caused death (itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State Registrar

Medical Certifica

3 Sulcide

29a. Certifiar (Check only one)

4 Homicida

29b. Signatura and title of certifier

32 Registrar's Signature

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

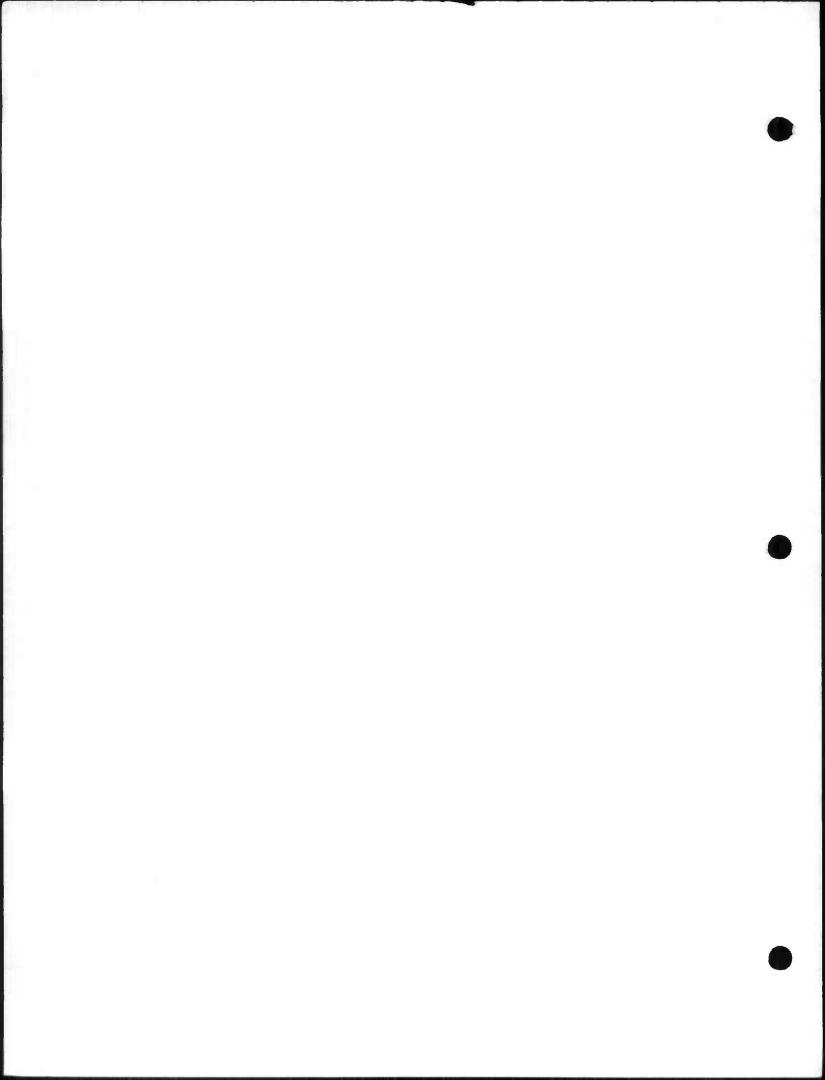
FOUND: RESIDENCE

(6)

| NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | 3. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be negative. The state Deor, of Health and Mental Hybride prior to bunial, cremation, or removal. | marked |
|--|---|--------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: Th | TO THE FUNERAL DIRECTOR: After this certificate the filed within 72 hours after death with the State | mark |

| STATE OF MARYLAND | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGI | ENE |
|-------------------|------------|----|--------|-----|--------|------|-----|
| C | ERTIFICATE | 0 | F DEAT | TH | | REG | NO. |

| | 1 - FOR STATE OF N | IARYLAND / DEPA | RTMENT OF H | | | GIENE B. NO. | | | |
|------------------|---|--|--|--|--------------------------------|---|-------------|--|--|
| Ī | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEA | ATN | . TIME OF DEATN | | | |
| 10 | Clarence Howard Seidenst | ricker Jr. | | | Jan. | 31, 199 | YEAR | 1:43 A. M | |
| - 3 | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs, last birthday) | | | | тн. | BIRTHPL | ACE (State or Foreign | |
| Ŋ, | 213-07-9307 1 M 2 F | 85 YRS. | MONTHS DAYS | HOURS MIN. | Feb. 8 | (Month, Day, Year) Feb. 8, 1910 Maryland | | | |
| DIRECTOR | Westminster Nursing Home | 9 | 96. CIT, IOWN | | stminste | | | rroll | |
| E | 10a. STATE 10b. COUNTY | 10c. CI | TY, TOWN OR LOCAT | ION | | | 1 | Od. INSIDE CITY | |
| | Maryland Carroll 10s. STREET AND NUMBER | | Westmir | | | | | LIMITS? | |
| AA | 100. STREET AND NUMBER | | -10 | ZIP CODE | | 10g. CITIZ | EN OF WH | AT COUNTRY? | |
| FUNERAL | 411 London Court | | | | 157 | | | States | |
| | 1 Never Married 2 X Married FORCES? 1 | EVER IN U.S. ARMED | | ENDENT OF HISPAI cify Cuben, Mexico | | | Hack, 1 | - American Indian, White, atc. | |
| B | 3 Widowed 4 Divorced IF YES, GIVE W | AR OR DATES | 1 TYES | 2 NO Specif | fy: | | Specify: | tale i do e | |
| | 15. DECEDENT'S EDUCATION | 14. DECEDENT | 'S USUAL OCCUPATION | M | THE WIND | OF BUSINESS/INDU | CTOV | White | |
| <u> </u> | (Specify only highest grade completed) | (Give kind of | work done during mo | st of working | 100. KIND | OF BUSINESS/INDU | SIRT | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 + |) | trician | | | Bethle | hem | Steel | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NA | AME (First, Middle, I | Maiden Surneme) | | | |
| BE (| Clarence Howard Seidens | | | | | Rosina | | Kerr | |
| 2 | Gladys Seidenstricker | 19b. MAILIN | IG ADDRESS (Street a | | | | | 21157 | |
| | | | | | | tminster | | | |
| | 20a. METNOD OF DISPOSITION 1 | 20b. PLACE AND DATE cemetery, crematory or Carro | EOFDISPOSITION (Ne rother place) O. L. Crema | tions Tr | /01 /9 6 ² | oc. LOCATION — C | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | | |
| | > 7 | | 4 | ricts Fi 12 Washi | ngton Rd | ome & Ch | nste | r, MD 21157 | |
| | Katherine Pritts - Sweit | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications the shock, or heart fellure. List only one ceu | t ceused the death. Do se on each line. | not enter the mo | de of dying, euc | ch sa cardisc or | reapiratory arre | at, | Approximate interval Between | |
| | IMMEDIATE CAUSE (Finel | Carcino | | 1 0 |) / | | | Onset and Death | |
| | resuming in death) , a | | | , , | 9/20 | | | 4 ms | |
| | DUE TO | (OR AS A CONSEQUENCE | OF): | | | | | | |
| S | Sequentially list conditions, | (OR AS A CONSEQUENCE | 05. | | | | | | |
| CERTIFICATION | if any, leeding to immediate cause. Enter UNDERLYING | (ON AS A COMSECUENCE | OFJ: | | | | | | |
| 임 | CAUSE (Diseese or injury | (OR AS A CONSEQUENCE | OF: | | | | | | |
| Ē | that initisted events resulting in death) LAST | (or no n oursessence | 0.17. | | | | | | |
| 岜 | d | | | | | | | | |
| AL (| PART II. Other significant conditions contributing to | deeth but not resulting | g in the underlyin | g ceuse given in | | AS AN AUTOPSY | | VERE AUTOPSY FINDINGS | |
| | Coremy Arts. | y Dire | 011 | | | YES 2 1 NO | | MAILABLE PRIOR TO COMPLETION OF CAUSE | |
| G | | | | _ ''' | TES 2 V NO | F DEATH? | | | |
| Σ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | ATH (Check only one) | UNCERIA | | | | | |
| \overline{S} | EXAMINER? HOSPITAL: | | OTHERS: | | | | | | |
| ΙλS | 1 ☐ YES 2 ☐ MO 1 ☐ Inpatient 2 ☐ 27. MANNER OF DEATH 28e. DATE OF | INJURY 28b. TI | | e 5 🗆 Reeldence | 1 | | | | |
| | 1 Natural 5 Pending (Month, D | | NJURY WO | RK? | 286. DESCHIBE | NOW INJURY OCC | UNED | | |
| BY | 2 Acctdent investigation | 5 11 11 11 11 | M 1 | | | 281. LOCATION (Street and Number or Rural Route Number. | | | |
| ED | 3 Suicide 8 Could not be building. | F INJURY — At home, ferm etc. (Specify) | s, street, factory, offic | • | City or Town | | or Rural Ro | ite Number, | |
| <u></u> | 29e. CERTIFIER | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: On the best of e | | | | | | | and manner so stated | |
| 잉 | | | — — — — — — — — — — — — — — — — — — — | | | | 1-1 | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | lon in | n | 29c. LICENSE NU | | 29d. DATE | SIGNED (| Month, Day, Yeer) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU | | pe, Print) | | / | 0 | 1 | form, mi | |
| | 7 . | WS SIGNATURE | 15 -1.n | -11 (| 14~ | 1C+11 | 4-1 | , form, m | |
| | FFR - 1 1996 July 1 | Muchankad | 11 | | | | | | |



| hysician | | Decedent's Neme (First, Middle, L. | Montg. Ct | | | <i>tificate o</i> n n Stearn | | 2. Data of De Month | Reg. No. | Yaar | 3. Tima of Death |
|---|--------|--|---|--|--|--|--|--|--|--|---|
| /Medical Examiner | 1 | 4a. Facility Neme (If not institution, gi | Stea | ms | | | 4b. City, Town, or | Januar | 4 27 | 1996 ty of Death | 10:26 ar |
| | | Suburban Hospit | a1 | | | | Bethsda | 1 | Mon | tgome | ry |
| neral ector | | | Sax 7.A 1□M 2XIF | 199 (In yrs. le 197 | ast birthday) Yrs. | if Under 1 Yea Months Day | | 8. Data of Bir (Month, Da Sept.1 | th ly, <i>Year</i>) 5,1908 | | place (State or Foreign ntry) INSAS |
| a-f ahow | | 10a. Stata 10b. County TEXAS Waryland Montgo | | 10c. City | , Town or Lo | | GEORGETOWN | | | | 10d. Insida City Limits 1 ☐ Yas 2 ☑ No |
| al', or itama 23a or 28e-f show Examiner must be notified at the Funeral Director | a Dila | 10e. Street and Number 30716 8614 Lynbrook Dri | 8ERRY CREEK | DRIVE | | 10f. Zip Coda | 70620 | | 10g. Citizen of United | | |
| r Itama 23a diner must Funeral | 5 | 11. Merital Status | 12. Was Decedent Armed Forcas | t Ever in U,S | S. 13. V | Was Decedant of f Yes, specify Cu | Hispenic Origin? (S | pecify Yas or No o Rican, atc.) | - 14. Ra Bio | ce - Amari | |
| natural, or indicate Example 1 | 2 | 1 Nevar Married 2 Married 3 Novel 4 Divorced | 1 ☐ Yas 200 If Yas, Giva Yaer or Datas: | | 1 | I□Yas 2□kNo | o Specify: | | Speci | ily: Wh | nite |
| lete | | 15. Decedant'a E (Specify only highest gr | ducation rada complated) | | 16a. Deced (Giva i lifa. D | lent's Usuel Occi <i>kind of work do</i> n DO NOT usa <i>retli</i> | upation a <i>during most of wo</i> red) | rking | 16b. Kind of I Baptis | | |
| rt, pre Medical I | | Elamantary/Secondary (0-12) | Collage (1-4or 5+ | 5+) | | al Worke | | | Dapers | | ildren |
| other traumatic event, the Medical To Be Completed | 3 | 17. Fathar's Nama <i>(First, Middla, Las</i> Henry Wilson | | | | | 18. Mother's Nar Mary M | na <i>(First, Middle,</i> IcCrory | , Meiden Sume | ma) | 1 |
| amme | | 19e. Informant'a Name/Raiationship | (Type, Print) | | 19b. Mailin | g Addrass (Stree | et and Number or Ru | ıral Routa Numb | er, Clty or Town | n, Stata, Zip | Coda)98117 |
| hert | - | Cyrus R. Stearns | | OOL DI | /206 🚨 | Syacamor | Avenue, | N.W., | Seattle | , was | nington |
| 0 0 | 1 | 20a. Method of Disposition 1 X Bunal 2 ☐ Cramation 3 [| | Ce | metary, crem | sition (Nama of natory or other p | , | Data | 20c. Location | | |
| Important: If it and Injury or o | - | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice | • | Fak | | | | | _ | | |
| any Ir | | Muchan Q | V-TT | | Bet | thesda-C | Chevy Chas | | | Wisco | eral Home/ onsin Ave. |
| icion | | 23a. Part1. Entar tha disaasa, or con shock, or heert feilure. List only | npiications that cause y one causa on aach | | 348 Bet | thsda, M | Maryland ying, such es cardia | | | 1 | Approximate Interval Between Onaet and Death |
| es the burleHransit | | 23a. Part1. Enter the disease, or conshock, or heert feilure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, taeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated awants resulting in death) Last | a | Due to (or | 348 Bet | uence of): | | or respiratory a | | el | Interval Between |
| es the buriel-transit and ledical Examiner | | Immediata Causa (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, laeding to immediata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last | a | Due to (or | as a consequence of c | uence of): | ying, such es cardia | tullify | Press, | | Interval Between Onset and Death |
| legical Examiner | | Immediata Causa (Final disassa or condition rasulting in death) Sequentially list conditions, if any, laeding to immadiata causa. Enter Undarlying Causa (Disassa or Injury that initiated awants | a | Due to (or | as a consequence of c | uence of): | ying, such es cardia | cor respiratory a | Press, | ontribute to | Interval Between |
| be detached for use as the bufal-transit are by Physician/Medical Examiner | | Immediata Causa (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, laeding to immediata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last | a | Due to (or | as a consequence of c | uence of): | ying, such es cardia | 23b. Did | Tobacco use o | ontribute to 3 Pro | o the cause of death? |
| page 2 should be detached for usa es the burlal-transit united and Physician/Medical Examiner | | Immediata Causa (Final disassa or condition rasulting in death) Sequentially list conditions, if any, laeding to Immadiata causa. Enter Undarfying Causa (Disassa or Injury that initiated awants rasulting in death) Last | a | Due to (or | as a consequence of c | uence of): | ying, such es cardia | 23b. Did | tobacco use o Yes 2 No an autopsy | ontribute to 3 Pro | o the cause of death? the beby 4 Unknown ara autopsy findings railable prior to morpletion of causa |
| sctor, page 2 should be detached for usa es the bunal-transit | | Immediata Causa (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, laeding to immediate causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Pert II. Other significant conditions of the conditions of the cause (Disaasa or Injury that initiated avants rasulting in death) Last | a | Dua to (or Dua to (or | as a consequence of the conseque | thsda, A ar the mode of distribution of the mode of distribution of the mode of distribution of the mode of the mo | ying, such es cardia. LUC LUC givan in Part i. | 23b. Did 1 24a. Was perfo | tobacco use of Yes 2 No | 3 Pro | o the cause of death? The beby 4 Unknown Tara autopsy findings railable prior to mepletion of causa death? Yes 2 No |
| Affet fulls cartificate has been signed by the attending physicial funeral director, page 2 should be detached for use as the but thori: To Be Completed by Physician/Medical | | Immediata Causa (Final disassa or condition rasulting in death) Sequentially list conditions, if any, laeding to immadiate causa. Enter Undarfying Causa (Disassa or Injury that initiated avants rasulting in death) Last Pert II. Other significant conditions of the conditions of th | a | Due to (or Due to (or Due to (or Due to result of the second of the second or the s | as a consequence of c | thsda, A ar the mode of divine uence of): uance of): uance of): t 3 DOA C | ying, such es cardial LUC LU-C givan in Part i. 26. Placa of Dai other: 4 □ Nursing H ury et | 23b. Did 1 = 24a. Was perfe | tobacco use o Yes 2 No an autopsy med? Yes 2 No ona) dance 6 Oo | ontribute to 3 Pro 24b. Way ave con of 11 | o the cause of death? The beby 4 Unknown Tara autopsy findings railable prior to mepletion of causa death? Yes 2 No |
| or: Affar this cartificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of a cartion: To Be Completed by Physician/Medical Examiner | | Immediata Causa (Final disassa or condition rasulting in death) Sequentially list conditions, if any, laeding to Immadiata causa. Enter Undarfying Causa (Disassa or Injury that initiated awants rasulting in death) Last Pert II. Other significant conditions of the conditions of th | a | Dua to (or Dua to (or Dua to (or Dua to (or but not rasulation) | as a consequence of the conseque | thsda, A ar the mode of divine uence of): uance of): uance of): t 3 DOA C | ying, such es cardial LUC LUC givan in Part i. 26. Placa of Dai other: 4 Nursing H ury et ork? Yas 2 No | 23b. Did 1 24a. Was perfo | tobacco use o Yes 2 No an autopsy med? Yes 2 No ona) dance 6 On how injury occur | ontribute to 3 Pro | o the cause of death? The beby 4 Unknown Tara autopsy findings railable prior to mepletion of causa death? Yes 2 No |
| or: Affar this cartificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of a cartion: To Be Completed by Physician/Medical Examiner | | Immediata Causa (Final disassa or condition rasulting in death) Sequentially list conditions, if any, laeding to Immadiata causa. Enter Undarfying Causa (Disassa or Injury that initiated awants rasulting in death) Last Pert II. Other significant conditions of the conditions of th | a | Dua to (or Dua to (or Dua to (or Dua to (or Dua to (or Dua to (or Dua to (or Dua to (or Dua to (or dua to (or Dua to (or Dua to (or Dua to (or Dua to (or | as a consequence of the conseque | thsda, Marthe mode of drawn th | givan in Part i. 26. Placa of Dai where: 4 Nursing H ury et ork? Yas 2 No | 23b. Did 1 24a. Was perfo | tobacco use of Yes 2 No ona) dance 6 On how injury occurrently street and Numer, Steele on ona occurrently occurre | 24b. W 24b. W 25c of 11 25c of 11 25c of 12 25c of 15c of | o the cause of death? beby 4 Unknown are autopsy findings allable prior to impletion of causa daath? Yes 2 No |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are State of Maryland / Department of Health and Mental Hygiens 96 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month Dra que Jon 711114 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGES GENERAL HOSPITAL CHEVERL If Under 24 Hrs. PRINCE GEORGES If Under 1 Yaar Birthplaca (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Day, Year, 6. Sex 7. Aga (In yrs. last birthday) Months Days Hours Min. 1 MM 2□ F 205-17-5847 Yrs JAN. 15,19 WASH. D.C. Usual Rasidance of Dacedani 10a, Siala 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No MD. PRINCE GEORGES COTTAGE CITY 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? 3711 43rd AVE. U.S.A. 14. Rece - Amarican Indian, Black, Whita, atc. 20722 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritel Stelus 1 Navar Married 2 Married ☐ Yas 2 No Yas, Giva 1 ☐ Yas 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Year or Deles: WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/industry 15. Dacedent's Education (Specify only highest grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) DISH WASHER RESTAURANT 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surname) RAYMOND SPRAGUE IDA STUEHM 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) D. SPRAGUE JAMES SAME AS 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Steta Data 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) FT. LINCOLN CEMETERY 1/31 BRENTWOOD, MD. 22. Name end Address of Fecility M00091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsal and Death Chronic obstructive fulm many disease Immediata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if eny, laeding to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants Dua to (or as a consequence of) Due to (or as e consequance of) resulting in deeth) Lest Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 E M 1 ☐ Yes 2 ☐ No 25. Was case rafarrad to medical 26. Placa of Death (Check only ona) axaminar 1 Yes Hospital: 2. No Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 🗆 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day) 27. Mannes of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury el Work? Year 1. @Natural 1 Yas 2 No Invastigation 2 Accident 6 Could not be datarmined 3 C Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Hamicide

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Certification: To

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29e. Cartifier

(Check only one)

31. Data filed (Month, Day,

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 or 28=f show any highry or other traumatic event, the Mexical Evantmen must be notified at applies.

Baltimore, Maryland 21215-0020

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Box 68760. or Attending Physician: The law requires that the death certificate be P.0. Division of Vital Records, death. after deatl filled in by 24 hours a Hospital completely

> State Registrar

29b. Signature and title of certifie

29c. Licansa number

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha Ilma, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

m 23a) (Type, Print)

32. Ragistrar's Signatura Julia Davidson Rardall

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

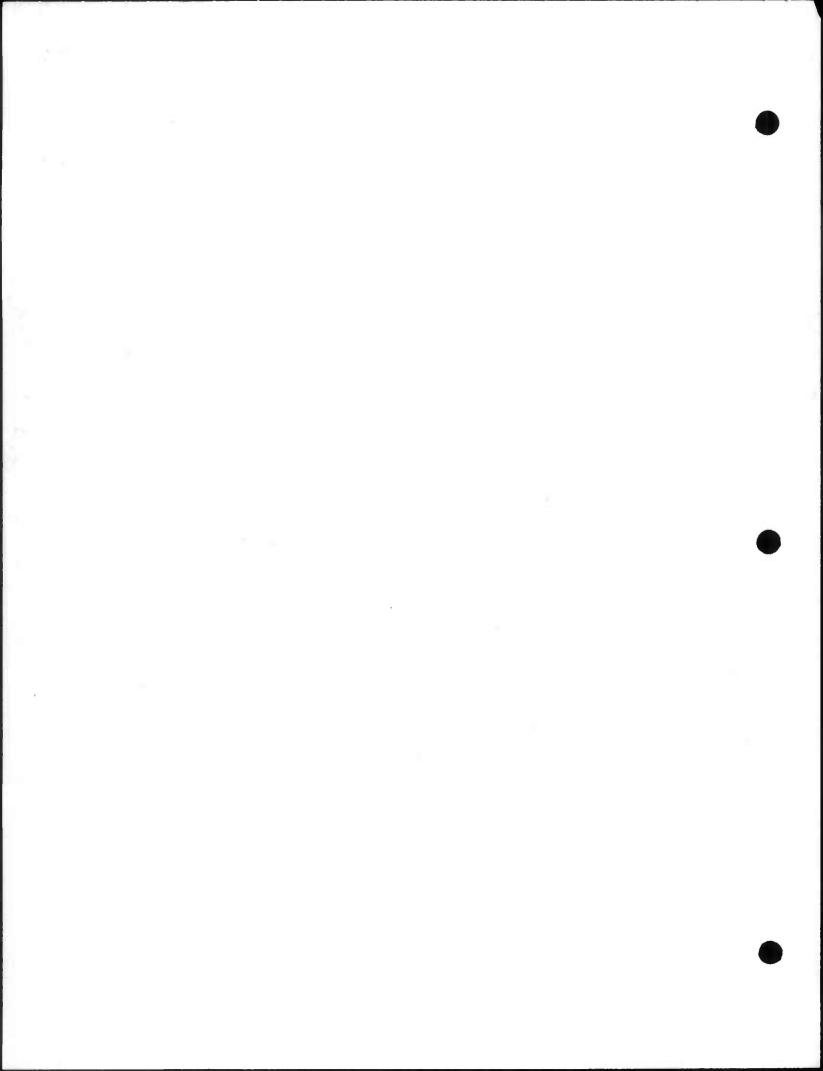
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| 578-52-0328 ¹□м²∑X* | | | | | | | | | | | | | | | | | |
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| James O'Brien | | | | | | | | | | | | | | | | | |
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| Rev. Robert O. 1 | McMain | 1 | | | | | | | | | 100 | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE A | ND DATE OF D | ISPOSITION | | , wasi | | | | | | | | | | | |
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| | 4. SOCIAL SECURITY NUMBER 578-52-0328 9a. FACILITY NAME (If not institution, give Carroll Manor No RESIDENCE OF DECEDENT 10a. STATE 10b. COUN Maryland Princ 10a. STREET AND NUMBER 4922 LaSalle Roca 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) James O'Brien 19a. INFORMANT'S NAME (Type/Print) Rev. Robert O. 1 20a. METHOD OF DISPOSITION 15t Burlel 2 Cremetion 15t Burlel 2 Cr | 4. SOCIAL SECURITY NUMBER 5. SEX 578-52-0328 9a. FACILITY NAME (If not institution, give street and number) Carroll Manor Nursing Hore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Prince George 10a. STREET AND NUMBER 4922 LaSalle Road 11. MARITAL STATUS 1 Never Merried 2 Married 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) James O Brien 19a. INFORMANT'S NAME (Type/Print) Rev. 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| BALLIMORE, MARYLAND 21215-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, oremation, or removal. | te medical examiner must be notified at once. |
|---|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the full be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPARTA | | | MENTAL HYGIEN | | |
|------------------------------------|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Harry LeRoy | Smith | | | | January 2 | 6,1996 | 11:34 A. M |
| | | SEX 6. AGE (In yrs. I | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. | BIRTHPLACE (State or Foreign Country) |
| * | 100-10-0724 | × 1 × 2 × 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 | YRS. | HTHS DAYS | HOURS MIN. | April 14. | 1912 F | ennsylvania |
| ~ | 9e. FACILITY NAME (If not institution, give street | | | | OR LOCATION OF DE | ATH | | OF DEATH |
| Ö | Holy Cross Hospit | al | | Silver | Spring | | Monto | omery |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c, CITY, T | OWN OR LOCAT | ION | | | 10d, INSIDE CITY |
| E | Maryland Montgo | merv | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | 1 2114 | er Spr | ZIP CODE | | 10a, CITIZEI | N OF WHAT COUNTRY? |
| ER/ | 11387 Columbia Pik | e # B3 | | | 20904 | | S.A. | |
| FUNERAL | 11. MARITAL STATUS | . WAS DECEDENT EVER IN U.S. A | RMED | 13. WAS DEC | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yes | | BACE - American Indian |
| ВУ Е | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES 2 | (NO | If yes, sp | ecify Cuban, Maxica 2 NO Specify | n, Puerto Ricen, etc.) | Black, White, atc. | |
| | | | | | | | | white |
| E | 16. DECEDENT'S EDUCATI (Specify only highest grade con | | ECEDENT'S USI Give kind of work te. Do NOT use re | done during mo | ON st of working | 16b. KIND OF BU | SINESS/INDUS | TRY |
| 3 | Elementary/Secondary (0-12) | Onege (1-4 or 5 +) | umbing | | | Machine | t 0 -l | 1 * 1 11 |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 1110 | anorng | Liligatile | | Wasning ME (First, Middle, Maiden | | ventist Hospit |
| | Benjamin Franklin | Smith | | | 5.00 | | | |
| BE | 19e, INFORMANT'S NAME (Type/Print) | | 9h MAILING AD | DBESS (Street o | Mary La | amina Sech: | rist | |
| 2 | Addie L. Smith | | | | | | | , MD 20904 |
| | 20. METHOD OF DISPOSITION | 20h PLACE | ANDDATEGER | MEDICALION /A/a | me of | DATE 200 LO | CATION OIL | on Town State |
| | 1 🖄 Buriel 2 🗆 Cremation 3 🗆 Removal | from State cemetery, o | awn Cel | piece) Metery | Jan 29 | 1996 | 200kvi | 110 MD |
| 4 | 21 SIGNATURE OF FUNERAL SERVICE LICENS | IEE | | 22. NAME AN | D ADDRESS OF FA | CILITY | | |
| | ET () | bleban | | 25/ 0- | | lakoma | Funera | al Home, Inc. |
| _ | 22 PART I Enter the dispesse or ser | | | 204 US | Troit St | . NW Wash: | inaton. | DC 20012 |
| | 23. FART I. LINES HIS GISTABEE, OF CONT | plications that caused the d | eath. Do not | enter the mo | de of dylna suci | as cardiac or mani | cotoni amani | I Annoulmet |
| | | only one cause on each lin | leath. Do not le. | enter the mo | de of dying, auci | n as cardiac or reapi | ratory arrest | Approximata interval Between |
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J. REGISTRATE'S SIGNATURE Julia d'unician hardalle

JAN 3 0 1996



DIVISION OF VITAL RECORDS, P.O. BOX 68760

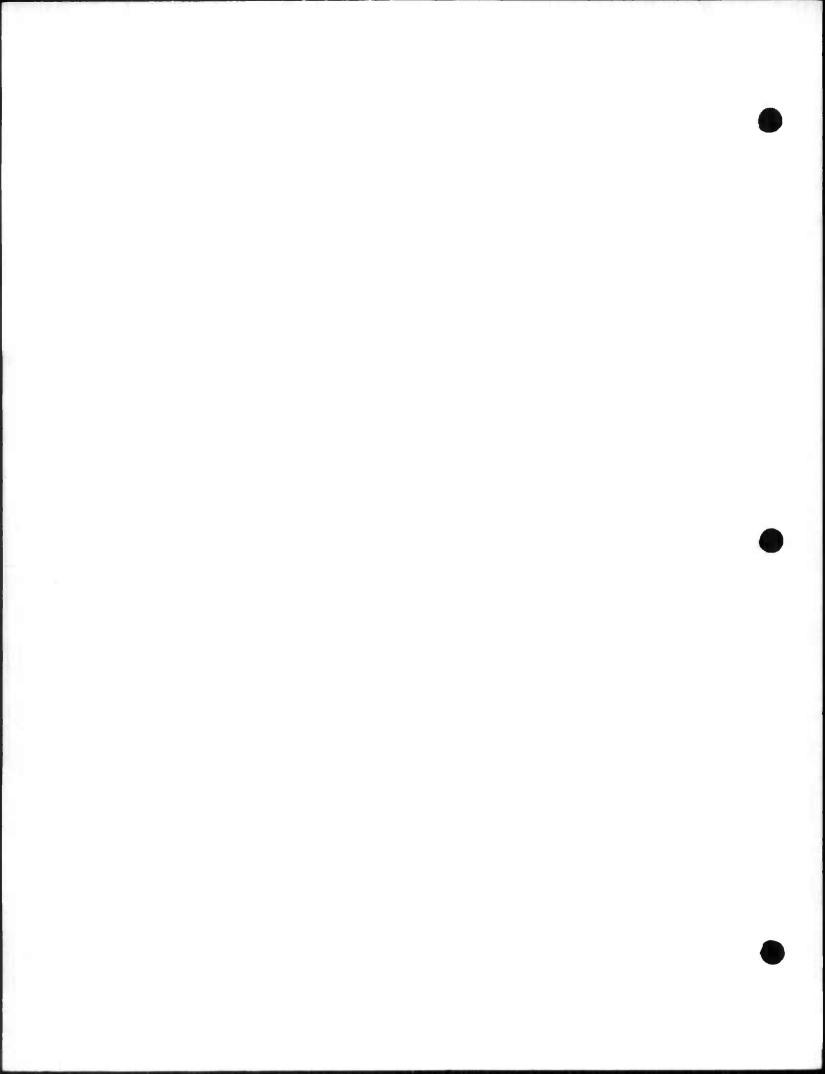
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENI |
|----|---|----------|
| AR | CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | | | HEALTH AND | MENTA | L HYGIEN | | | | |
|------------------|--|--|-----------------------------|--|---|---------------------------------------|----------------------------------|-----------------------|-------------------|---------|--------------------------|----------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | | | | |
| | Charles Louis | Smith. Jr. | | | | | January 26, 1996 5:05 | | | 5.05 | AM | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. / | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | . BIRTH | PLACE (State or Fo | | | | |
| | 577-36-8128 | 577-36-8128 1 M 2 F 67 | | | | | Sep | th, Day, Year) | | | ington, | DC |
| FUNERAL DIRECTOR | 5704 Brewer Hous | | #201_ | | | or location of o | ZAIN | | Mon | | nery | |
| EC | 10a. STATE 10b. COUNT | TY | | 10c. CITY, TO | OWN OR LOC | ATION | | | | | 10d. INSIDE CITY | |
| | Marvland Mor | ntgomery | | RO | ckvil | 16 | | | | | LIMITS? 1 YES 2 X | |
| 7 | 10a. STREET AND NUMBER | 1090027 | - | 1 110 | | Of, ZIP CODE | | 10g. CITIZEN OF WH | | | | NO |
| ER | 5704 Brewer Ho | ouse Circle. | . #201 | | | 20852 | | | | | States | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EV | ER IN U.S. AF | RMED | 13. WAS D | ECENDENT OF HISPA | NIC ORIGI | N7 (Specify Yes | | | - American Indi | 90. |
| BY F | 1 Never Married 2 X Married 3 Widowed 4 Divorced | FORCES? 1 ⊠ 1 IF YES, GIVE WAR O | OR DATES | NO | | specify Cuban, Mexic S 2 X NO Spec | | Rican, etc.) | | Specif. | , White, etc. y: | |
| Ö | 15. DECEDENT'S EO | UCATION | 16a, DE | ECEDENT'S USU | AL OCCUPA | ION | 16 | b. KINO OF BU | SINESS/INDI | STRY | White | |
| COMPLETED | (Specify only highest grad Elementary/Secondary (0-12) | te completed) College (1-4 or 5+) | (G | live kind of work to Do NOT use rel | done during r | nost of working | | | JII. 2007 III. 20 | | | |
| 릴 | , , , , , | 1 | Adv | ertisi | na Ex | ecutive | | Advert | isina | Δασ | ncv | - 1 |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S N | | | | nge | ncy | |
| 8 | Charles Louis S | Smith, Sr. | | | | Alma (| hthr | ie | | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING ADI | DRESS (Street | end Number or Rural | | | n, State, Zip C | ode) | | |
| 2 | Lee Ann Smith | | 5 | 704 Br | ewer 1 | House Cir | cle. | #201 | Rock | vi11 | e. MD 2 | 0852 |
| | 20a, METHOD OF DISPOSITION 1 (A Burlat 2 Cremation 3 Rea | movel from State | 20h PLACE | ANDDATEGED | SPOSITION | | DA | | CATION - C | | | 0032 |
| | 4 Donation 5 Other (Specify) | | Gate | of Hea | ven C | emetery | | Sil | ver S | prin | ng, Mary | land |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0831 22. NAME AND ADDRESS OF FACILITY RODERT A. PUMP Preval Home | | | | | | | | | | | |
| | Bethesda-Chevý Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | |
| | 23. PART I. Enter the diséeses, or shock, or heart failure | complications that cer . List only one ceuse of | used the de on each line | eath. Do not d | enter the m | ode of dying, au | ch aa car | diac or reap | ratory arre | nt, | Approximation interval B | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | Onset and | |
| - 1 | disease or condition resulting in death) | a. Renal | | | | | | | | | 3 mon | ths |
| | | | | OUENCE OF): | | | | | | | | |
| No. | Sequentially list conditions, | W- | | eroscle | erosis | 5 | | | | | 20 ye | ars |
| Ē | if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OR | | | | | | | | | | |
| 윤 | CAUSE (Disease or Injury | e. Hyperl | | .demia | | | | | | | 30 ye | 30 years |
| CERTIFICATION | resulting in death) LAST | unit military wants | | | | | | | | | | |
| 빙 | | 0. | | | | | | | | | 1 | |
| AL | PART II. Other significent condition | na contributing to dee | th but not r | reaulting in th | e underlyl | ng ceuse given in | Part I. | 24a. WAS AN PERFOR | | | WERE AUTOPSY FI | |
| 음 | | | | | | | | 1 YES 2 | | | COMPLETION OF C | AUSE |
| M | | | | | | | | | | 1 | 1 YES 2 | 10 |
| ż | DID TOBACCO USE CONT | TRIBUTE TO CAUSE | OF DEA | TH YES | M NO | UNCERTAL | N | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER: | | | | | | | | | | | |
| IS | 1 TES 2 NO | 1 Inpatient 2 ER/ | | | me 5 🖔 Rasidence | 6 🗆 Oth | Other (Specify) | | | | - 1 | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATH | 28e. DATE OF INJU (Month, Day, Ye | | 28b. TIME OF INJURY | | JURY AT | 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| ₩ | 1 Natural 5 Pending 2 Accident Investigation | | | | | YES 2 NO | | | | | | |
| | 3 Suicida 6 Could not be 4 Homicide determined | eme, farm, street | i, factory, off | ce | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of my k | nowledge, de | with occurred at | the time de | te and place, and du | to the co | unofal and mar | والجريد | | | |
| <u> </u> | | ER: On the baels of examin | | | | | | | | | and manner as a | lated. |
| | 296. SIGNATURE AND TIPLE OF CENTIFIE | _ | | | | 29c. LICENSE NU | | ,, | | | | |
| BE | XIIII YOUN | My Co |) | | | | | | | | (Month, Day, Year) | |
| 임 | MAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE OF | DEATH (ITE | M 27) (Type, Prin | t) | D379 | 15 | | Jar | nuar | y 26, 1 | 996 |
| | Jeffrey P. Indr | | | | | ronue #2 | -40 | C; 1 | m Comment | 20.00 | MD 200 | [|
| | | | GNATURE / | adell. | 11a A | enue, #3 | -40, | PITA6. | spri | ng, | MD 209 | 02 |
| | JAN 31 19 | 196 " Julia 20 | WAREN'S | W. C. C. | | | | | | | | - 1 |





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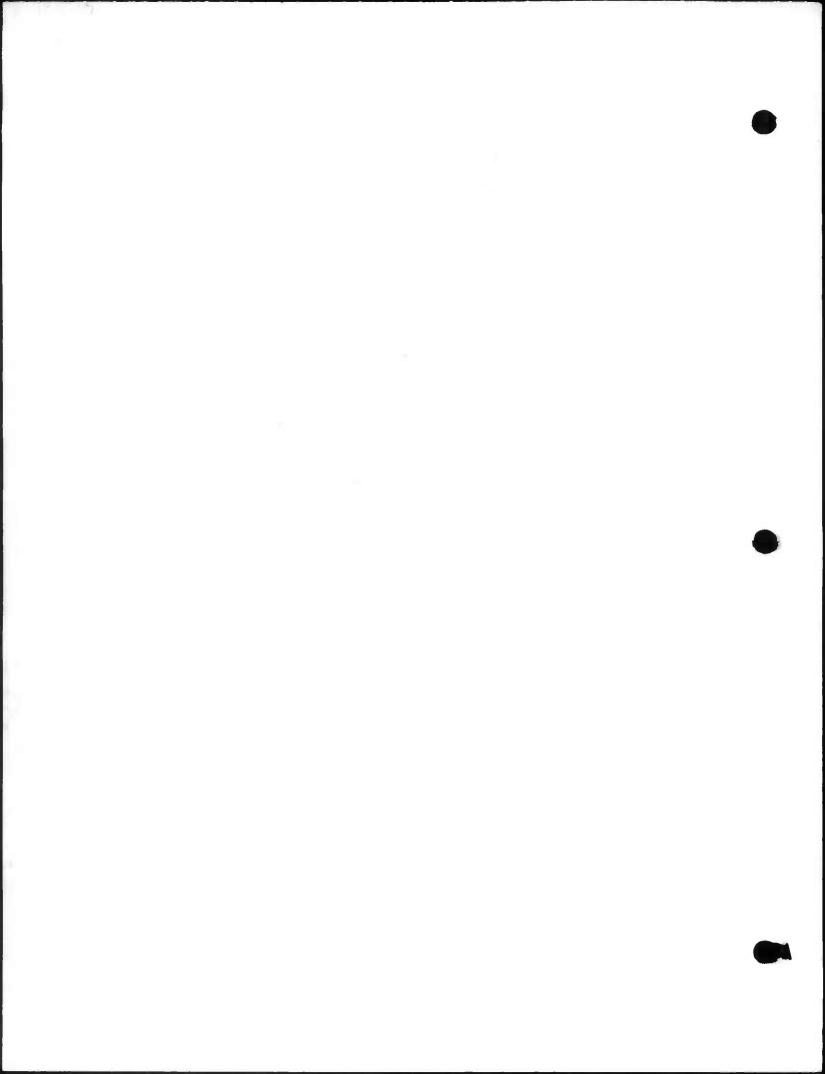
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float heath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL HYGIEN | | | | |
|------------------|---|---|--|--|--|--|---|--|--|--|
| 100 | 1. DECEDENT'S NAME (First, Middle, Last) | | She | ridan | | 2. DATE OF DEATH DAY | V YEA | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE MONTHS DAYB HOURS MIN. April | | | | | | | | | |
| OR | 9a. FACILITY NAME (If not institution, give s Potomac Valley Nu | R LOCATION OF DEA | on of Death 9c. COUNTY OF DEATH Montgomery | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | n town on Locat | | | 10d. INSIDE CITY LIMITS? 1 ∑ YES 2 □ NO | | | | | |
| FUNERAL | 10a. STREET AND NUMBER 4201 Cathedral Av | venue N. W. | | | 20016 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? t YES IF YES, GIVE WAR OR D | 2 X NO | if yes, sp | ENDENT OF HISPANI belty Cuben, Maxican 2 NO Specify: | | or No 14, R. | ACE — American Indian, lack, White, atc. | | |
| COMPLETED | 15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 18a. DECEDENT'S (Give kind of w life. Do NOT use Homem | rork done during mo e retired.) | | 16b. KIND OF BUS | n Home | Y | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) James Linahan | | Homein | ancı | | NE (First, Middle, Maiden : | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) John J. Sheridan | | | | Ave. N. | oute Number, City or Town W. Washin | n, State, Zip Code) | | | |
| | 20e, METNOD OF DISPOSITION 1 Burial 2 Cremation 3 Remote Donation 5 Other (Specify) | G | netery, crematory or off ate of He | eaven Ce | metery | 1/29 Sil | cation — chy or ver Spr | ing, MD | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LE | 6 | 095Ce | | | V Washing | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Due to for As A Consequence of: | | | | | | | | | |
| CERTIFICATION | Sequentially flat conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Arteriosclerotic Heart Disease Unknown Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| A | PART II. Other eignificent condition Osteoporosis | e contributing to deeth b | out not reculting l | n the underlying | csuee given in F | Pert i. 24a. WAS AN / PERFORI | MED? | 14b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| IAN: N | DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE OF DEAT | | UNCERTAIN | D | | 1 12 2 0 | | |
| PHYSICIAN: MEDIC | 1 TYES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/Outs 28a. DATE OF INJURY (Month, Day, Year) | patient 3 DOA | OF 28c, INJ | a 5 ☐ Raeldenca 8 JRY AT RK? | Other (Specify) 28d. DESCRIBE NOW IN | JURY OCCURED | | | |
| ED BY | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide a Could not be detarmined | 28s. PLACE OF INJURY building, atc. (Spec | ES 2 NO | NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| COMPLET | | CIAN: To the best of my know R: On the basis of examination | | | | | | e(a) and manner se stated. | | |
| TO BE C | 29h. SIGNATURE AND TITLE OF CERTIFIER | Mon | | mo | 29c. LICENSE NUME | | 29d. DATE SIGN | ED (Month, Day, Year) | | |
| | James R. M OD 31. DATE FILED (Month, Day, Year) JAN 3 0 1996 | O COMPLETED CAUSE OF DE OF JC. 207 32. REGISTRAR'S SIGN O July Murch | Вгори | ^ | Gait | hersbur | gmp | 20877 | | |
| | 2 0 0 1950 | 7 | Odrod | | | | | | | |





BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float her death. Page 6 may be retained by the hispitation.

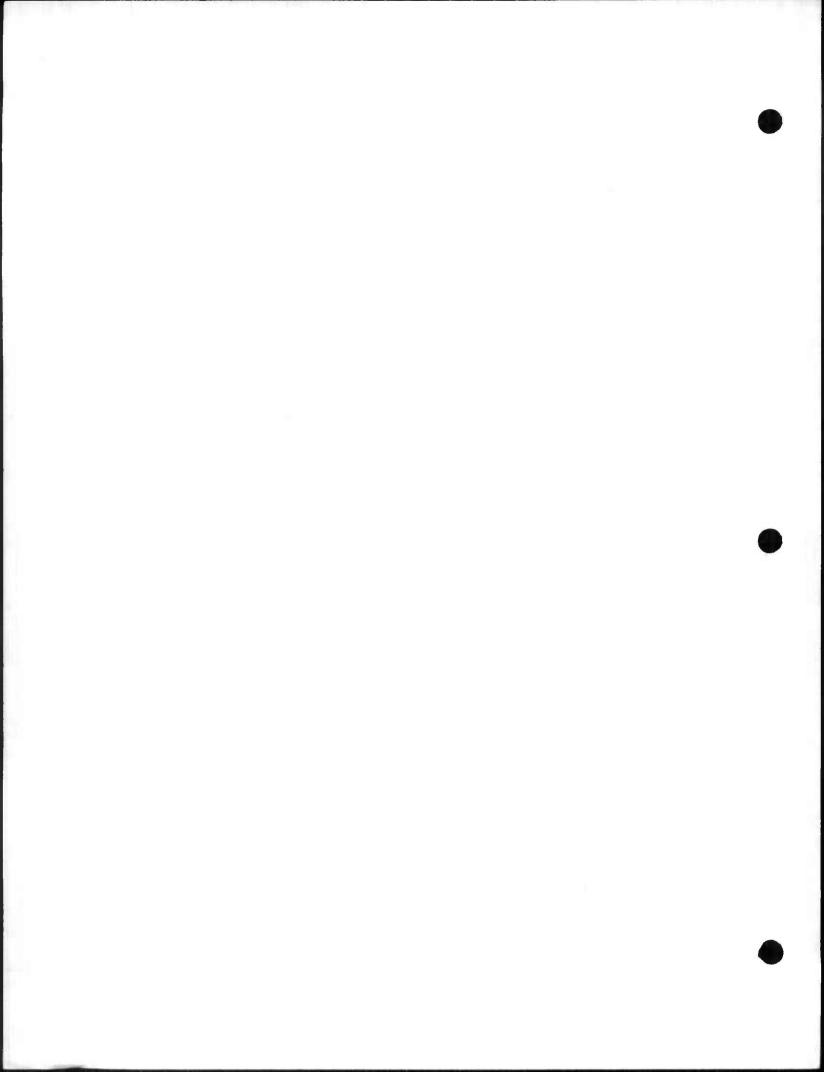
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / | DEPARTMENT | OF HEALTH ANI | MENTAL | HYGIENE |
|---------------------|------------|---------------|--------|----------|
| CI | ERTIFICATE | OF DEATH | | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFICA | ENT OF H | EALTH AND I | MENTAL HYGIEN | | | | |
|-----------------|---|--|--|-----------------------------|---|--|--|---|--|--|
| 18 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | | 3. TIME OF DEATH | | |
| | | Peter F. Sc | ott | | | January 2 | 1:30 P M | | | |
| 1 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTN | 0. BIR | THPLACE (State or Foreign | | |
| 1 | 076-10-5011 | | 76 YRS. MON | THE DAYS | HOURS MIN. | (Month, Day, Ybar) Mar. 28, | 1919 Ne | w York | | |
| | 9a. FACILITY NAME (If not institution, give : | street and number) | 9b. | CITY, TOWN O | R LOCATION OF DE | | 9c. COUNTY OF | | | |
| DIRECTOR | Carriage Hill-B | ethesda | | Beth | esda | | Montg | omery | | |
| <u>D</u> | 10a. STATE 10b. COUNT | Υ | 10c. CITY, 10 | WN OR LOCATI | ON | | | 10d. INSIDE CITY | | |
| 1 5 | Maryland Mon | tgomery | 200 | Bethe | ഭർമ | | | LIMITS? | | |
| | 10e. STREET AND NUMBER | - Bomery | | | ZIP CODE | | 10g, CITIZEN OF | WHAT COUNTRY? | | |
| FUNERAL | 7720 01d Chest | er Road | | | 20817 | | United | States | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | | 13. WAS DECE | NDENT OF HISPAN | IC ORIGIN? (Specify Yes | or No- 14, RA | CE — American Indian. | | |
| BY F | 1 Never Merried 2 Married 3 Wildowed 4 Divorced | FORCES? 1 X YES | | If yes, spe 1 TES | city Cuban, Maxicas 2 🙀 NO Specify | , Puerto Rican, etc.) | | ck, White, etc. | | |
| | | WW II | | | | <i>'</i> . | | White | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | (CATION is completed) | (Give kind of work | done during mos | N t of working | 16b. KIND OF BU | SINESS/INDUSTRY | | | |
| 1 2 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Staff Ma | | | m - 1 | | | | |
| M | 17. FATHER'S NAME (First, Middle, Lest) | | Stall Ma | mager | 40 4407117010 1141 | TE 16 | phone C | ompany | | |
| | Warren Scott | | | | | a Van Evel | | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADD | RESS (Street an | | oute Number, City or Tow. | | | | |
| 2 | Margaret A. Scot | tt | | | | Bethesda, | | nd 20817 | | |
| | 20a. METHOD OF DISPOSITION | | PLACE AND DATE OF DE | | | | CATION - City or | | | |
| | 1 X Burial 2 Cremation 3 Ram 4 Donation 8 Other (Specify) | cem | etery, crematory or other p | le Ceme | pring, L | 996 Full | | New York | | |
| 1 3 | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | 22. NAME AND | ADDRESS OF FAC | HI ITY | | | | |
| | Rosel to | and | M00198 | Robert | A. Pump Bethes | hrey Funer da-Cheyy (| al Home Chase I | / B ^c 20814-3501 | | |
| | 23. PART I. Enter the diseases, or | complications that caused | I the deeth. Do not a | 155/ W | 1SCONSIN | Ave., Beth | resda: M | 20814-3501 Approximate | | |
| | snock, or neert failure. | List only one cause on ea | ach line. | | , . , | the control of the pr | atory arroat, | Interval Between | | |
| | iMMEDIATE CAUSE (Final disease or condition | Respirat | ory Arrest | | | | | Onset and Death | | |
| | resulting in death) | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| z | | Colon Ca | ncer | | | | | | | |
| 은 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| 2 | CAUSE (Disease or Injury | c. | | | | | | | | |
| 造 | that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | | d | | | | | | | | |
| AL (| PART II. Other significant condition | ne contributing to death b | contributing to death but not resulting in the underlying cause given | | | | | | | |
| | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| MEDIC | | | | | | | 41 | OF DEATH? | | |
| ä | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | F DEATH YES [| □ NO □ | UNCERTAIN | | | | | |
| NA. | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (C | | | | | | | |
| | EXAMINER? HOSPITAL: OTHER: | | | | | | | | | |
| SI | 1 🗆 YES 2 🙀 NO | 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DES | | | | | | | | |
| PHYSIC | 27. MANNER OF DEATH | 28a. DATE OF INJURY | | 1 NJURY WORK? M 1 YES 2 NO | | | | | | |
| BY PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF INJURY | | WOR | | | | | | |
| ВУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be | 20a. DATE OF INJURY (Month, Day, Year) | - At home, farm, street | M 1 YE | | 28t, LOCATION (Street a City or Town, State) | nd Number or Rural | Route Number, | | |
| ED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | - At home, farm, street | M 1 YE | | 28t, LOCATION (Street a City or Town, State) | nd Number or Rurel | Route Number, | | |
| ED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be datermined 29a. CERTIFIER (Check only) | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spec | At home, farm, street | M 1 YE , tectory, office | end place, and due | City or Town, State) o the cause(a) and man | ner as stated, | | | |
| ED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be datermined 29a. CERTIFIER (Check only) | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spec | At home, farm, street | M 1 YE , tectory, office | end place, and due | City or Town, State) o the cause(a) and man | ner as stated, | | | |
| COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be datermined 29a. CERTIFIER (Check only) | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Special Cidan: To the best of my knowledge) ER: On the best of axamination | At home, farm, street | M 1 YE, tectory, office | end place, and due | City or Town, State) to the cause(a) and man ime, data and placa, an | ner as stated, d due to the cause | | | |
| BE COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be datermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Special Injury building) (Special Injury building) (Special Injury building) (Special Injury) (Months Injury) (Mo | — At home, farm, street fity) — At home, farm, street at and/or investigation, in | M 1 YE , tactory, offica | end place, and due to | City or Town, State) o the cause(a) and man lime, data and placa, an | ner as stated, d due to the cause 29d, DATE SIGNE | (a) and manner as stated. | | |
| COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be datermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATUSE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS F PERSON WIN | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge). Or the best of axamination in the best of the best | - At home, farm, street ify) - At home, farm, street ify) - At home, farm, street ify) - At home, farm, street ify) - At home, farm, street ify) | M 1 Yt, tectory, office | and place, and due to the to 29c. LICENSE NUM | o the cause(a) and man ime, data and placa, an | ner as stated. d due to the cause 29d. DATE SIGNE Janua | (a) and manner as stated. D (Month, Day, Year) | | |
| BE COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be datermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WN George W. Graves | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Special Place of Injury building) etc. (Special P | - At home, farm, street edge, death occurred at a and/or investigation, in ATN (ITEM 27) (Type, Print) WISCONSIN | M 1 Yt, tectory, office | and place, and due to the to 29c. LICENSE NUM | o the cause(a) and man ime, data and placa, an | ner as stated. d due to the cause 29d. DATE SIGNE Janua | (a) and manner as stated. D (Month, Day, Year) | | |
| BE COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be datermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WN George W. Graves | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge). Or the best of axamination in the best of the best | - At home, farm, street edge, death occurred at a and/or investigation, in ATN (ITEM 27) (Type, Print) WISCONSIN | M 1 Yt, tectory, office | and place, and due to the to 29c. LICENSE NUM | o the cause(a) and man ime, data and placa, an | ner as stated. d due to the cause 29d. DATE SIGNE Janua | (a) and manner as stated. D (Month, Day, Year) LTY 29, 1996 | | |





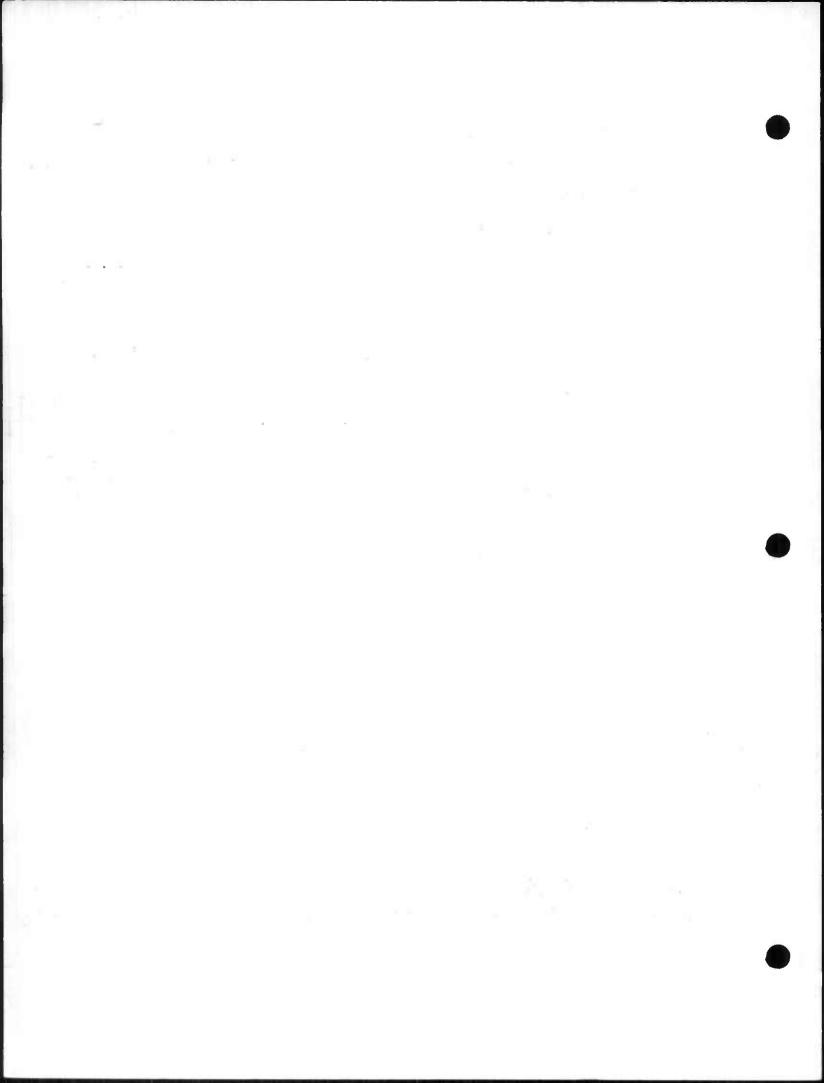
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

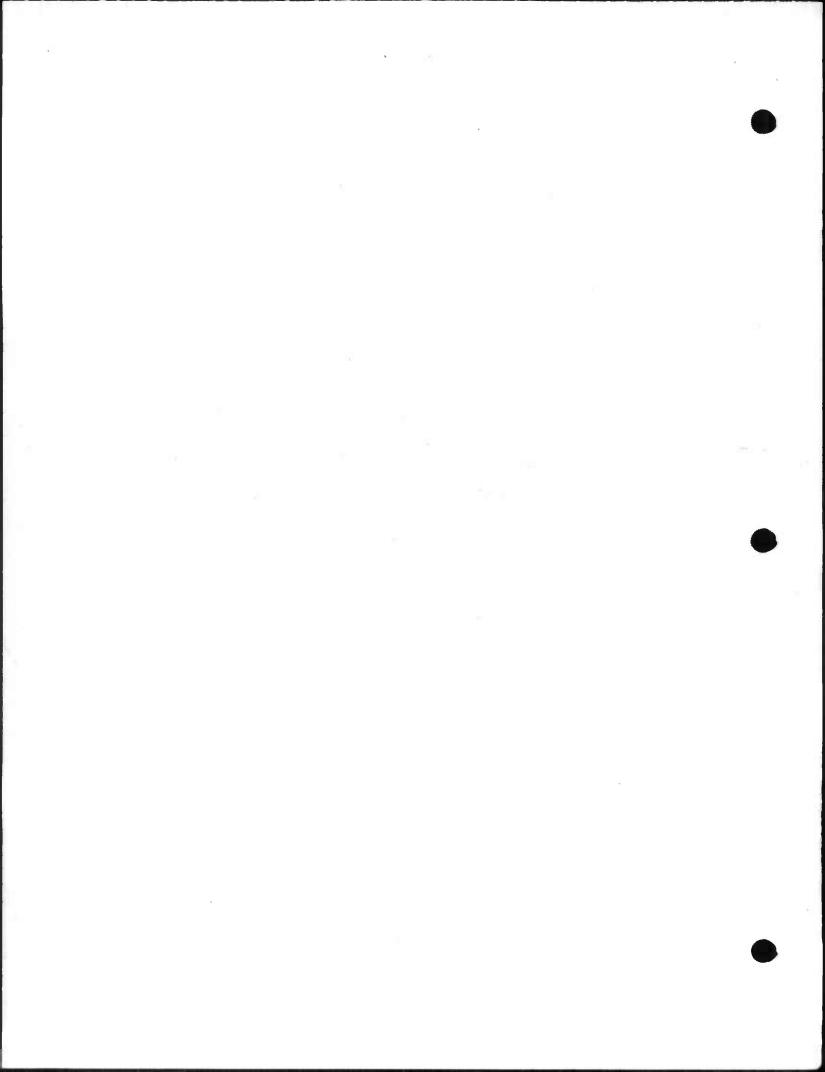
| | REGISTRAR | | CERTIFIC | JAIE U | r DEAL | п | REG | . NO. | | |
|--|---|--|---|--------------------------------------|--------------------------|------------------------|---|-----------------------------|------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH | | | | | | | | TH DAY | YEAR 3 | TIME OF DEATH |
| -1 | Katherine Hardisc | Inomas | | | | Jan 26,1996 YEAR 5 | | | 5-1014 M | |
| | | 8. AGE (In yrs. | | F UNDER 1 YEAR | | 24 HRS. | 7. DATE OF BIRT | н Тоот | 8. BIRTHPI Country) | ACE (State or Foreign |
| | 578-56 -0178 1078 1 □ M 2 🕅 F | 88 | YRS. | | | | | | WASHI | NGTON N.C. |
| _ | 9s. FACILITY NAME (if not institution, give street and number) | | Db. CITY, TOWN | OR LOCATIO | ON OF DE | ATH | | INTY OF DEA | | |
| <u> </u> | 8704 Old Branch Ave, | | | Clir | nton | | | Prir | nce Ge | orge's |
| DIRECTOR | 10e, STATE 10b, COUNTY | | 10c. CITY, | TOWN OR LOC | ATION | | | | Ti | Od. INSIDE CITY |
| ĕ | Maryland Prince George | S | Cl | inton | | | | | , | LIMITS? |
| | too. STREET AND NUMBER | | | | 10f, ZIP CODE | | _ | 10g. CIT | | AT COUNTRY? |
| 3 | 8704 Old Branch Avenue | | | | 2073 | 5 | | 1 | U.S | .A. |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT | EVER IN U.S. | ARMED | 13. WAS D | ECENDENT O | F HISPAN | IC ORIGIN? (Speci | ty Yes or No- | t4. RACE - | - American Indian, |
| | 1 Never Married 2 Married FORCES? t [IF YES, GIVE WA | | XIP | | specify Cube ES 2 2NO | n, Mexicen Specify: | , Puerto Ricen, et | C.) | Specify: | White, etc. |
| B | 3X Widowed 4 Divorced | | | | | | | | Cauca | asian |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. | DECEDENT'S U (Give kind of wo | rk done during i | | g | 16b. KIND C | F BUSINESS/IN | DUSTRY | |
| COMPLET | Elementary/Secondary (0-12) College (1-4 or 5+) | | ille. Do NOT use | , | | | Daine | o Coor | rola (| Co. Schools |
| Ž | 12th 4 | SC | hool Te | eacher | | | | | ge s c | D. SCHOOLS |
| 3 | 17. FATHER'S NAME (First, Middle, Last) | | | | | er's MAN Catti | ME (First, Middle, M | | Moore | |
| 4 | Charles T. Hardison | 1 | | | | | | na | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | Beach | | | |
| i | Robert Thomas 20a. METHOD OF DISPOSITION | | | | | | | | | |
| | t X Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | cemetery. | CE AND DATE OF Crematory of other Car H1. | Place Com | oterv | _ | | c. LOCATION — | | |
| | 21, SIGNATURE OF FUNERAL SERVICE LICENSEE | | uar III. | | | 100 |)6 IS | witland | d, Mai | cyland |
| | 61 / 6-11 | | | | | | Lee F | | | |
| | OR Y. ONTE | | 6633 Old Alexandr | | | | andria F | ria Ferry Rd Clinton, M | | |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Out to (or as a consequence of): | | | | | | | | Onset and Death | |
| | d | | | | | | | | | |
| 3 | PART II. Other algorificant conditions contributing to o | leath but no | ot reaulting in | in the underlying cause given in Par | | | | AS AN AUTOPSY ERFORMED? | / 1 | VERE AUTOPSY FINOINGS WAILABLE PRIOR TO |
| | | | | | | | _ 10 y | ES 2 NO | | OMPLETION OF CAUSE OF DEATH? |
| | DID TODACCO LICE CONTRIBUTE TO CAL | ICE OF D | EATH VEC | | | EDTAIN | | | 1 | YES 2 NO |
| į | DID TOBACCO USE CONTRIBUTE TO CAL | | LACE OF DEATH | | | ERTAIN | 1 [2] | | | |
| 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | - | OTHER: | | | | | | |
| PHTSICIAN: M | 1 YES 2 NO 1 Inpetient 2 D | | 26b. TIME | - 1 | NJURY AT | sidence | 6 Other (Specification of the Specification of the | | CUREO | |
| 2 | 1 Natural 5 Pending (Month, Da | , Year) | INJU | RY | WORK? | NO | 200. DESCRIBE | 10W INJURY OC | CURED | |
| EIED | 3 Suicide 6 Could not be determined 28e. PLACE OF building, a | INJURY — Att. (Specify) | t homa, farm, st | reet, fectory, of | fice | | 261. LOCATION (S City or Town, | Street and Number State) | er or Rural Ro | ute Number, |
| ا ب | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of s | ny knowledge | , death occurred | at the time. de | eta and place | and due | to the councils or | d manner es et | nted. | |
| COMPL | | | | | | | | | | and manner se stated. |
| O BE O | MANUAL STOP OF CERTIFIER COMMENTED CAND | SIGNATURE AND TITLE OF CERTIFIED AUGUSTO AUGUS | | | | | | | | |
| | // | 'S SIGNATUR | Ø | | | | | / / | | |
| II. | JAN 3 0 1996 Julia | Thursto | reveally | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exect TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to but IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumati |
|--|
|--|

| | 1 - STATE REGISTRAR | STATE OF MARYLAND | | TMENT OF H | | MENTAL HYGIENE | | | | |
|--------------------|---|---|------------------------------------|--|--|---|---|--|--|--|
| | 1. OECEOENT'S NAME (First, Middle, Lest) WILLIAM ROBE | ERT TUBBS, SF | | | | 2 DATE OF DEATH | 27 š t | 3. TIME OF OEATH 7:58 A | | |
| | 4. SOCIAL SECURITY NUMBER 218-14-4012 | 5. SEX 1 X M 2 F F 72 | last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 10/23/23 | 6. B | MRTHPLACE (State or Foreign Ountry) | | |
| FOR | 90. FACILITY NAME (ti not institution, give s 10244 Hotel RD RESIDENCE OF DECEDENT | | | - | nopville | EATH | 9c. COUNTY OF DEATH Worcester | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | rcester | | Y, TOWN OR LOCAT | | | 10d. INSIDE CITY LIMITS? 1 \(\text{YES} \) 2 \(\text{Y} \) NO | | | |
| FUNERAL | 100. STREET AND NUMBER 10244 Hotel RD |) | | 101 | 21813 | P. | | OF WHAT COUNTRY? | | |
| BY | 11, MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 FIF YES, GIVE WAR OR DATES | | | city Cuben, Mexica | NIC ORIGIN? (Specity Yee in, Puerto Ricen, etc.) y: | 1 | RACE — American Indian, Black, White, atc. Specify: white | | |
| COMPLETED | 15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | (Give kind of w life. Do NOT us | usual occupation work done during mose retired.) | st of working | 166. KIND OF BUS | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) William Robert | Tubbs | | | 18. MOTHER'S NA | ME (First, Middle, Melden S e Ann Sava | Surneme) | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Elizabeth Mae Tu | ıbbs | 19b. MAILING 102 | AOORESS (Street of 44 Hotel | RD Bis | hopville, M | Stere, Zip Code D 218 | | | |
| | 20e, METHOD OF DISPOSITION 1 | oval from State cemetery, o | e AND DATE Coremetory or of Unit | | odist | 1/30/96 Bis | hopvil | le, MD | | |
| | · N. Sic | 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 21811 | | | | | | | | |
| | 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart feliure. List only one cause on sech line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) OUP TO OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | Sequentielly list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (DR AS A CONSEQUENCE OF): d. | | | | | | | | | |
| | PART ii. Other algnificent condition | e contributing to death but not | t resulting i | n tha underlying | ceuse given in | Part i, 24a, WAS AN A PERFORM 1 YES 2 | NED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| PHYSICIAN: MEDICAL | DID TOBACCO USE CONTR | | | H (Check only one) | UNCERTAII | N D | | 1 YES 2 NO | | |
| BY PHYSI | 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 1 Inpatient 2 ER/Outpatient 28e. DATE OF INJURY (Month, Day, Year) | 3 DOA | E OF 28c. INJU | JRY AT | 8 Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCURE | D | | |
| | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At the building, etc. (Specify) | treet, factory, office | | 28f. LOCATION (Street an City or Town, State) | nd Number or Ru | irel Route Number, | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner as stated. | | | | | | | | | |
| TO BE (| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 130. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3733 Herlthury Druf | | | | | | | | | |
| | | | EM 27) (Type | 733 H | Bul | 7 Drup | 213 | 847 | | |
| 15 | JAN 3 0 1996 | 32 REGISTRAR'S SIGNATURE | 16 | | | | | | | |



| 020 | physician. |
|-------|------------|
| 215-0 | attending |
| | 9 |
| NDS | hospital |
| 4 | the |
| _ | 6 |
| MARY | retained |
| | 28 |
| T | may |
| 0 | 9 |
| Σ | Page |
| ALI | death. |
| | |

as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 6876

| TO BE COMPLETE | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|---|---|
| al examiner must be notified at once. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| the funeral director, page 5 should be detached for use yeal. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| ter death. Page 6 may be retained by the hospital or at | TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at |
| BALTIMORE, MARYLAND 212 | DIVISION OF VITAL RECORDS, P.O. BOX 6876 |

| | FOR STATE OF MARYLAND / DEPAR STATE OF MARYLAND / DEPAR CERTIF | RTMENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | | | | | | |
|------------|---|---|---|--|--|--|--|--|--|
| , | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF OEATH 3. TIME OF OEATN | | | | | | |
| - 1 | CARL David TRIPLET | ··rp· | JANUARY 31 | 1996 7:55 A M | | | | | |
| - 1 | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthdey) | IF UNDER 1 YEAR IF UNDER 24 HRS. | NOER 1 YEAR IF UNDER 24 HRS. 7, DATE OF BIRTH 8 | | | | | | |
| ı | 214-07-6964 1 M M 2 🗆 F 94 YRS. | MONTHS DAYS HOURS MIN. | Sept, 30,19 | of West Virginia | | | | | |
| | 9e. FACILITY NAME (if not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF | | c. COUNTY OF DEATN | | | | | |
| 5 | 44 | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | H // eggN y | | | | | | | |
| | | umberland | / | LIMITS? | | | | | |
| - 10 | 10%. STREET AND NUMBER | 101, ZIP CODE | 10 | 1 X YES 2 NO | | | | | |
| EHAL | 113 South Street | 2150 | | 454 | | | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF NISPA | | No. 14. RACE — American Indian. | | | | | |
| | 1 ☐ Never Married 2 ☑ Married FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES? | If yes, specify Cuban, Mexic 1 ☐ YES 2 🔀 NO Spec | | Black, White, etc. Specify: | | | | | |
| 0 | 3 Widowed 4 Divorced | | | White | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of | S USUAL OCCUPATION work done during most of working use retired.) | 16b. KIND OF BUSINE | ESS/INDUSTRY | | | | | |
| OMPLE | Elementary/Secondary (0-12) College (1-4 or 5 +) | stodian | CT-+ | F 100 / / | | | | | |
| Ž. | 2 C U | | IAME (First, Middle, Meiden Sun | of Maryland | | | | | |
| - 11 | Perry C. triplett | ma - | | | | | | | |
| | | G AOORESS (Street and Number or Rura | | ruer Stete, Zip Code) | | | | | |
| 2 | Ada triplett 113 | South ST. | Cumberlos | wd, md. 21502 | | | | | |
| ı | 200. METHOD OF DISPOSITION 20b. PLACE AND DATE | OF DISPOSITION (Name of | PATE 20c. LOCAT | TION — City or Town, State | | | | | |
| | 1 Description 3 Removal from State cametery, cremetory or description 5 Other (Specify) | other place) Memorial Pari | 5-96 CUM | borland, Md. | | | | | |
| ı | 21. SIONATURE OF FUNERAL SERVICE LICENSEE | Z2. NAME AND ADDRESS OF F | | altimore Avenue | | | | | |
| | ▶ Ernest a. Riley, fr. | Cumberland, | | 21502 | | | | | |
| j | 23. PART I. Enter the diseases, or complications that caused the deeth. Do ahock, or heart failure. List only one cause on each line. | not enter the mode of dying, su | ch as cardiac or respirate | ory arreat, Approximate interval Between | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | Nolan | | Onset and Death | | | | | |
| ł | reaulting in death) DUE TO (OR AS A CONSEQUENCE OF | | | 37 | | | | | |
| . 1 | - DOE TO TON AS A CONSESSENCE | <i>J</i> F). | | | | | | | |
| ALION | Sequentially list conditions, if any, leading to immediate | OF): | | | | | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | |
| | that Initiated events DUE TO (OR AS A CONSEQUENCE C | DF): | | | | | | | |
| r I | resulting in death) LAST | | | | | | | | |
| ايُ | PART II. Other aignificant conditions contributing to death but not resulting | in the underlying cause given i | | | | | | | |
| 3 | | | PERFORME 1 YES 2 | COMPLETION OF OWNER | | | | | |
| MEDIC | | | | 1 YES 2 NO | | | | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y | ES 🗆 NO 🔯 UNCERTA | IN 🗆 | | | | | | |
| N N | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEA | ATN (Check only one) | | | | | | | |
| H TSICIAN: | 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA | OTHER: 4 Nursing Home 5 Residence | 6 Other (Specify) | | | | | | |
| 5 | 27. MANNER OF DEATN 28e. OATE OF INJURY (Month, Day, Year) IN | JURY WORK? | 28d. DESCRIBE HOW INJU | JRY OCCURED | | | | | |
| 2 | 2 Accident Investigation | M 1 YES 2 NO | | | | | | | |
| 2 | 3 Sulcide 8 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, term, street, factory, office City or Town, Street | | | | | | | | |
| | 29e. CERTIFIER | | | | | | | | |
| 7 | (Check only CENTIFTING PHYSICIAN: 10 the beat of my knowledge, death occur | | | | | | | | |
| COMPLE | 2 MEDICAL EXAMINER: On the beels of examination end/or investigati | | | ue to the ceuse(e) end manner es stated. | | | | | |
| <u>ا</u> ا | 29b. SIGNATURE AND TILE OF CERTIFIER | 29c. LICENSE N | | 9d DATE SIGNED (Month, Day, Year) | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Typ | D 1277 | 7 | | | | | | |
| | | | Then in the | 21502 | | | | | |
| | GUY FISCUS M.D., MEMORIAL HOSPITAL ME 31. DATE FILED (MONTH), Day, Voor) 32. REGISTRAR'S SIGNATURE | | BERLAND, MD | 21502 | | | | | |
| | FEB 0 2 1996 Sali Madean Ravile | K | | | | | | | |
| | | | | | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Q 6

| | | | | | Cer | tificate of | Death | | Reg. Nc | 000. | |
|------------|---|----------------|--|---|-------------------------------------|--|---|--------------------|----------------------|---------------------------------|-----------------------|
| | | | 1. Decedent's Nama (First, Middle, La. | st) | | | | 2. Data of Dea | ith | | e of Death |
| | Physici | | A | lfred Hu | ghston | Tuck | or | Month | Day 20 100 | Year | 05 714 |
| 3 | /Medi Examir | | 4e. Facility Neme (If not institution, give | | -B.12 1011 | Tuck | 4b. City, Town, or I | Jan. | 30,199 4c. County | | 05 PM |
| | L. AGITIII | ICI | Memorial Hos | spital at E | aston | | Easto | n | Tall | | |
| | Funeral | | Social Security Number 6. S | | rs. lest birthday) | If Under 1 Yeer | If Under 24 Hrs. | | | 9. Birthplaca (Sta | ta or Foreign |
| | Director | | 220-26-8704 | X) M 2□ F 64 | Yrs. | Months Days | Hours Min. | July 16 | 1931 | Marylar | |
| | ט | | Usuel Rasidance of Decedent | | | | | pulj 10 | ,1001 | 17202 3 202 | |
| | ylan | | 10a. Stata 10b. County | 10c. (| City, Town or Loc | cation | | | | 10d. Inside | e City Limits |
| | Ma Tred | tor | Maryland Talbot Tilghman 10e. Street and Number 10f. Zip Coda 21671 | | | | | | | 101 | Yes 2 No |
| | h the | ire | 10e. Street and Number | | - B I | 10f. Zip Coda | | | 10g. Citizen of V | Vhet Country? | |
| | h wil | a C | 5879 Tilghman Rd. | | | | 21671 | | U.S.A. | | |
| | 172 hours efter death with the Maryland *natural", or items 23a or 28a-f ehow added Examinet must be notified at | Funeral | 11. Meritel Status | 12. Was Decedent Ever in Armed Forcas? | U,S. 13. V | Vas Decedant of I | tispanic Origin? (S en, Maxican, Puart | pecify Yas or No- | 14. Rac | - American Indian | ٦, |
| 0 | oftar Dr. Re | | 1 Nevar Married 2 Married | 1. Yas 2 □ No | | | | rican, etc.) | | k, Whita, atc. | |
| 02 | Par. | by | 3 ☐ Widowed 4 ☐ Woivorced | If Yas, Giva Yaer or Datas: | 1 | □ Yas 2□ No | Specify: | | Specify | Whit€ | 9 |
| 21215-0020 | 72 h | Completed | 15. Decedant's Ed (Specify only highast gra | ducation | 16a. Deced | lant's Usual Occup | oation | kina | 16b. Kind of Bu | sinass/Industry | |
| 21 | C 2 | npidu | Elementary/Secondary (0-12) | Collega (1-4or 5+) | life. C | OO NOT usa ratire | during most of word) | 1 | | | |
| 2 | | S | 10 | | Carpe | nter | | | Constru | ction | |
| nd | ntal Hygind other | Be | 17. Fathar's Name (First, Middla, Last) | | | | 18. Mothar's Nam | | | a) | |
| yla | should and Meni | Lo | Alfred H. Tuck | er | | | Elsie | Jeffers | on | | |
| Maryland | N 6 8 8 | | 19a. Informant's Name/Reletionship (7 | Type, Print) | 19b. Mailin | g Address (Street | and Number or Ru | ral Routa Numbe | r, City or Town, | Stata, Zip Code) | |
| | | | Donna Tucker Gow | re | P.O. | Box 359 | Tilghman | Maryla | nd 2167 | 1 | |
| ore | Pages 1 and ment of Health ant: If them 27 ury or other 1 | | 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ | 20b | . Placa of Dispos cematary, cram | sition (Nama of natory or other ple | ce) | Deta | 20c. Location - | City or Town, State | R |
| E | Pag nent ant: h | | 4 Donation 5 Other (Specify | | apitol C | rematory | Jan. 3 | 1, 1996 | Dover 1 | Delaware | |
| Baltlmore, | permit. Page Department Importent: If any injury or once. | | 21. Signature of Funerei Sarvice Licen | -00 | 22. | Neme end Addre | ss of Facility | | | | |
| 0 | 89 = 8 | | Hamine E | Learne | | | Leonard bot St. | | | 2 91669 | |
| | | | 23a. Part1. Enter tha disease, or comp shock, or haart failura. List only | plications that caused the de | ath. Do not anta | ar tha moda of dyi | ng, auch es cardiac | or raspiratory ar | rast, | Approxi | mate |
| 4 | Physician | | STOOK, OF HAART TAILUTA. LIST OTHY | ona cause on aach inte. | _ | | | | | Onset a | Between and Death |
| 7 | /Medical | | tmmedieta Cause (Finel disaase or condition | Blata | () at | 0 | 2 -11- | Panom | 1 hor - 1 | 112-5 | 142.44 |
| | Examiner | | resulting In daeth) | e. Due to | (or es a consequ | uence of): | arolic | > | ous em | W C | regions |
| _ | D # | ner | | | | , | | | | | |
| | eath certificate be assouted attending physician and for use as the bunal-transit | Examiner | Sequentially list conditions. | b. Due to | (or as a consequ | uance of): | | | | | |
| o, | an a | | Sequantially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disaase or Injury that initiated evants | | | į | | | | | |
| 68760, | ate b | Medicai | that initiated evants resulting in daath) Last | | | | - 3 | | | | |
| 99 | ng pl | Ned Ved | Dua to (or as a consequence of): | | | | | | | | |
| Вох | endii r use | arv | | d | | | | | | i | |
| | 0 0 0 | Physician | Part II. Other significant conditions co | ontributing to deeth but not re | asuiting in the un | darlying causa gi | van in Part I. | 23b. Dld t | obacco use cor | tribute to the cau | se of death? |
| P.0 | at the by th | Phy | Sant | • | | | | 1)101 | res 2□ No | 3 Probably | 4 ☐ Unknown |
| | ss that gned b | by | Sophicen | ucy | | | | | | | |
| Records, | been sign | pe | | | | | | 24e. Was a | an autopsy med? | 24b. Wara autop evallable pr | sy findings for to |
| SC | 2 s | ple | | | | | | | (| completion of death? | of cause |
| | The law ate has b page 2 s | Completed | | | | | | 1 🗆 Y | as 28 No | 1 ☐ Yas | 2□ No |
| of Vital | | Bec | 25. Was casa (afarred to medical | | | | 26. Place of Dea | th (Check only or | na) | | |
| > | Physiclan: this certific ral director, | 0 | exeminer? | Hospital: | ☐ ER/Outpatiant | 3□ DOA Oti | 201. | oma 5 Rasid | | ar (Specify) | |
| | Ph er thi | n: T | 27 Mannar of Death | 28e. Date of Injury (Month, Dey Year) | | 28c. Inju Wo | | | ow Injury occurr | | |
| Division | is or Attending P s after death. I Director: After t d in by the funera | atio | 1.⊠Naturai 5 ☐ Panding 2 ☐ Accidant invastigation | | Injury | | Yas 2 □ No | | | | - 100 |
| Vis | Atta | if C | 3 Suicide 6 Could not be datarmined | 28a. Place of Injury - At | homa, farm, stre | eat, factory, office | | | | er or Rural Routa M | Vumber, |
| ā | d in Dir | Certification: | 4 _ Hollicide | building, atc. (Spec | ciry) | | | City or Tow | n, Stata) | | 1.75% |
| | To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral | | 29a. Cartiflar 1 Certifying Phy | ysicten: To the best of my ki | nowledga, daath | occurred at tha ti | ma, data and place | and due to tha | ausa(s) and me | nnar as stated. | |
| | n 24 n 24 n Pe Fu | edicai | (Check only 2 Medicat Exam | niner: On the basis of axamir and menner steta | nation and/or inv | astigetion, in my | opinion, deeth occur | red at the tima, o | deta and placa, a | and dua to the caus | sa(s) |
| | withir To th comp | Σ | 296 Signature and title of certifier | | | 29c. Licans | sa number | | 29d. Data signed | (Month, Day, Yea | ir) |
| | | 1 | 10111 10M | 20 (3d) | (111 | D 2 | 27409 | | 1 3 | 76 | |
| | | () | 30. Name and oddress of person who o | nom le led cause of death (It | am 22a) A | | , , = 1 | | | * | |
| | | - 2% | and the second of the second o | control ou cause of death fitt | em 23a) . r | Print) | | | | | |
| | | | Lawrence D. Bo | | | | Easton, | Maryland | 21601 | | |
| | Sta | te | Lawrence D. Bo | | Dut chma | ans Lane | Easton, | Maryland | 21601 | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 96 03867

| | | | | | C | Certificate of | Death | F | Reg. No. | | | |
|------------|---|----------------|---|------------------------------------|---------------------------------------|---|-----------------------|---------------------------------|-----------------|-----------------|--------------------------------|--------------|
| | | | 1. Decedent's Nama (First, Midd | fla, Last) | | | | 2. Data of Dea | | | 3. Tima of I | Death |
| | Physic | | MARY | EMILY T | HAMERT | | | Januar | v 23. 1 | Yaar 996 | 1:34 | n m |
| | /Med Exami | | 4a. Facility Nama (If not institution | | | | 4b. City, Town, or L | | | | 1.01 | p.111. |
| | Exam | 1101 | 6431 Bozr | nan Neavitt | Road | | Neavitt | | Tal | hot | | |
| | Funeral | | 5. Social Security Numbar | 7 | . Aga (In yrs. last birtho | day) If Undar 1 Yaar | if Undar 24 Hrs. | 8. Data of Birt (Month, Day | | | ce (Stata or | Foreian |
| | Director | | 213-74-9728 | 1□M 2∏F | 90 Yr | s. Months Days | Hours Min. | Month, Day | 2, Year) | | yland | |
| | | | Usual Residence of Dacedant | | | | | INOV. I | 4, 1300 | Mar | yranu | |
| | ylan | | 10a. Stata 10b. Count | | | | 10d | d. Insida City | / Limits | | | |
| | Ma Ta | to | Maryland Ta | lbot | Neavit | t | | | | | 1 Yas | 2 N 0 |
| | 1 the | Director | 10e. Street and Number | 10f. Zip Coda | | | 10g. Citizan of | What Country | y? | | | |
| | N N | ā | 6431 Bozr | nan Neavitt | Road | 21 | 652 | | USA | | | |
| | ne 2 | Funeral | 11. Marital Status | 12. Was Daced | | | | e - Amarican | indian. | | | |
| | ftar the | Fur | 1 ☐ Nevar Married 2 ☐ Ma | Armed Force | as? | Was Decedant of F if Yas, specify Cub | an, Maxican, Puarto | Rican, atc.) | Bla | ck, Whita, ato | c. | |
| 22 | 72 hours after death with the Maryland natural; or items 23s or 28s-f show licel Examiner must be notified at | þ | 3℃ Widowed 4 Divorce | if Yas Giva | AS: | 1 ☐ Yas 2X No | Specify: | | Specif | w Whit | White | |
| ŏ | 72 hours "natural", | 8 | 15. Deceda | nt's Education | 16a. D | ecedant's Usual Occup | pation | | 16b. Kind of B | usinass/Indu | atry | |
| 21215-0020 | n n | Completed | (Specify only high | ast grada complated) | (0 | Giva kind of work dona fa. DO NOT usa retire | during most of world) | | | , | | |
| 5 | s within jiena. r than * | E | Elamantery/Secondary (0-12) | Collega (1-4 | | ousewi fe | | | | | | |
| | Hygin Hygin | | 17. Fathar'a Nama (First, Middla | , Last) | | | 18. Mothar's Nam | a (First, Middle, | Maiden Suman | na) | | |
| Maryland | Mental Merked or arked or artic eve | To Be | Melvin Ber | tlev Lednum | 1 | | Ethel | Virgini | a Hadda | wav | | |
| 5 | 2 should be filed within and Mental Hygiena. Is marked other than aumatic event, the Ma | - | 19e. Interment's Name/Ralation | | | Mailing Address (Street | | | | _ | Code) | |
| 2 | | | | | | | | | | | July | |
| ď. | 1 an Haai em 2 | | George Carrol 20a. Mathod of Disposition | Inamert | | O. Box 37 | 4, Neavit | Data Data | 20c. Location | | n Stata | |
| Baltimore, | T it it | | 1 Sunial 2 Cramation | | ata | cramatory or other pla | | | | | | |
| Ë | tant tuny | | 4 Donation 5 □Othar (| | Neavit | t Cemetery | | ,1996 | Neavitt | , Mary | rland | |
| <u>a</u> | permit. Pagas 1 and 2 Department of Haaith a Important: If Item 27 is any injury or other trae | | 21. Signature of Funaral Sarvice | Licansee | | 22. Nama and Addra Harrison | | d Finer | al Home | | | |
| _ | 20 = 4 0 | | Dorrelan | 6 Lo | mande | 319 S To | lbot St | C+ Mi | obools | MD | 21663 | |
| | | | 23a. Part1. Enter tha disaasa, o shock, or haart failura. Lis | r complications that cau | usad tha daath. Do not | antar the mode of dyl | ng, such as cardiac | or raspiratory ar | rast, | A | oproximata | |
| | Physician | | | | | | _ | | | Ö | Onset and De | eath |
| | /Medical | | Immediate Causa (Final disaasa or condition | Con | SCASTIVE. | HEART 1 | FAILURE | | | 1 | Voses | |
| | Examiner | | rasulting in daath) | a | Due to (or as a con | nsequance of): | | | | | 10110 | |
| ١ | | je | | Col | conney Ar | - De | CEALE | | | 1 V | ELAC | |
| | cutex | Examiner | Sequentially list conditions. | 6. Sch | Due to (or as a cor | | | | | | CHILI | |
| o` | an ar | | Sequantially list conditions, if any, leading to immadieta cause. Entar Undarlying Cause (Disaase or injury | J | | | | | | | | |
| 68760, | certificata be executed ding physician and se as the burial-transit | Medicai | that initiated events | С. | Dua to (or as a con | sequence of): | | | | - | | |
| 89 | iffica g ph | Pe | rasulting in death) Last Dua to (or as a consequence of): | | | | | | | | | |
| | | | | d | <u> </u> | | | | | - | | |
| m | death o | Physician | Part II. Other significant conditi | and contribution to don't | the house mass an austrian a facility | ra visida de desa e accesa e la | on in Sout I | non Did e | obacco usa co | markhi da da di | ha aaaa af | l alo ado f |
| 0 | that the de led by the a datached i | hys | 1 _ | | | ia uridanying causa gi | van ni marti. | | | | | |
| a . | as that igned b be data | | HTRIAL HIC | RILLATION | / | | | 101 | es 20 No | 3 Probet | bly 4⊡U | nknow |
| S | S 60 | d by | • | , | | | | 24e. Was | an eutoney | 24b Wara | a autopay tir | ndinas |
| Ö | v requir been si should | Completed | | | | | | | med? | comp | abla prior to pletion of ca | |
| Records, | S S S | idu | | | | | | | | of de | ath? | |
| = | E # g | Co | | | | | | 1 🗆 Y | as 20 No | 1 U Y | Yes 2 N | lo |
| of Vital | Physician: Tha is this cartificate ha rai director, page | Be | 25. Was casa raferred to medical exeminer? | al | | | 26. Place of Dea | th (Check only o | ne) | | | |
| = | nyalo lis ce | 2 | 1 ☐ Yas 2 No | Hospital: 1 🗆 Inc | patient 2 ER/Outpe | atlent 3 DOA | ner: 4 D Nursing He | oma 5 Raaid | ance 6 Oth | ar (Specify) | | |
| | | | 27. Menner of Death Neturel 5 ☐ Pandi | 28a. Date of (Month. | Injury 28b. Tim Day Year) Inju | | ry at | 28d. Describe h | ow injury occur | red | | |
| Division | Attending in death. | atic | 2 Accident Invast | igation | | | Yes 2 □ No | | | | | |
| 5 | | tific | 3 Suicida 6 Could 4 Homicida detarr | nined 288. Placa of | Injury - At homa, tarm | , atraat, tactory, office | | 28f. Location (S City or Tow | traet and Numi | er or Rurai F | Routa Numb | er, |
| 5 | s aftar il Olrection by | Certification: | - Tolliolda | odilding | , atc. (Specify) | | | Ony or You | n, Gialay | | | |
| | ners ners y fille | | 29a. Certifiar Certifyi | ng Physician: To tha be | est of my knowledge, d | aath occurred at the tir | me, data end plece, | end dua to tha | eusa(s) end m | anner as stet | ed. | |
| | To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in | edical | (Check only 2 Medical one) | Examinar: On the basi and manna | is of axamination and/o | or invastigation, in my o | pinion, daath occur | red at tha tima, o | lata and place, | and dua to th | ha cause(s) | |
| | om thing | Σ | 29b. Signatura and titla of certific | ar Ø | | 29c. Licans | sa number | | 29d. Data signe | d (Month, Da | ay, Year) | |
| | ->-0 | | 14 | Bhem. | | 1 | 26350 | | ,/2 | 4/96 | | |
| | | | P V | | | | 16770 | | 1/2 | 1/10 | | |
| 20 | | | 30. Nama and addrass of person | 1_ | . , , , | | 11 | C1 3. | 1 | 0.00 | 0100 | 0 |
| | | | William (F. 31. Dete tiled (Month, Day, Year) | Bremer, M | | 00 South T | aibot St. | , St. M | cnaels | , IVID. | 2166 | J |
| | Sta Regist | | JAN 2 | 5 1996 | istrar's Signatura | what! | | | | | | |
| | Regist | al | SHIT D | UUUU A | The waster | - Alma | | | | | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 03868 State of Maryland / Department of Health and Mental Hygiene 96 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month Dey **Physician JAMES** ROBERT 1996 23 Taylor Jan 9:54 AM /Medical 4a. Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital at Easton Talbot Easton If Undar 1 Yaar if Under 24 Hrs. 8. Data of Birth
Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) **Funeral** Months 1√2 M 2□ F 230-68-8892 43 Director AUG. 12, 1953 VIRĞINIA Usuet Rasidance of Dacedant with the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23s or 28s-f shor traumetic svent, the Medical Examiner must be notified at 1 ☐ Yas 2X No MARION Director SMYTH 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 24354 USA RT.5 BOX 225 B pemit. Pages 1 and 2 should be filed within 72 hours effer deeth 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a and highry or other traumatic avent, the Medical Examinations. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indien, Bteck, White, etc. Wes Dacedant of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yas 2 No If Yas, Give Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Bustness/Industry BUILDING Elamantary/Secondary (0-12) Collega (1-4or 5+) 9 CONSTRUCTION WORKER CONSTRUCTION 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be MARY HALL 0 JOHN A. TAYLOR 19a. Informant's Name/Ralationship (Type, Print) 19b. Matling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MELISSA T. McKINNON RT.5 BOX 226 AA, MARION, VA 24354 20b. Ptace of Disposition (Nama of cematary, cramatory or other p 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) CLEGHORN BAPTIST CHURCH -26 SMYTHE COUNTY, VA CEMETERY
22. Name and Address of Facility
NEWNAM FUNERAL HOME, P.A. 21. Signatura of Funeral Service Licenses CFSP Newscem 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Finei diseasa or condition rasulting in death) rows Examiner Examiner The law requires that tha death certificate be executed physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that leated entered the control of the control o Dua to (or es e consequance of): Box 68760. Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yss 2 Probably 4 Unknown þ Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? peen comptation of cause of death? hes 1 Yas 2 No 1 Yas 2 No certificate Physician: Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlant 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? of a Attending Parties of the Attended Interestor: After 1 Natural 5 Panding 2 Accidant 1 ☐ Yas 2 No invasttgation 7:45 A AUTO ACCIDENT JAN. 23, 1996 6 Could not ba datermined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homlcida To the Hospital o within 24 hours of To the Funeral D' completely filled I ROADWAY RT. 328 EASTON, MD 21601 edicai 29a. Cartifian 1 Csrtifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. (Check only one) 25 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signetura end title of certifiar 29c. Licansa numbar 29d. Deta signed (Month, Day, Year)

THOMAS DIVILIO, M.D., 404 MARVEL COURT, EASTON, MD 21601

1-23-96

State Registrar

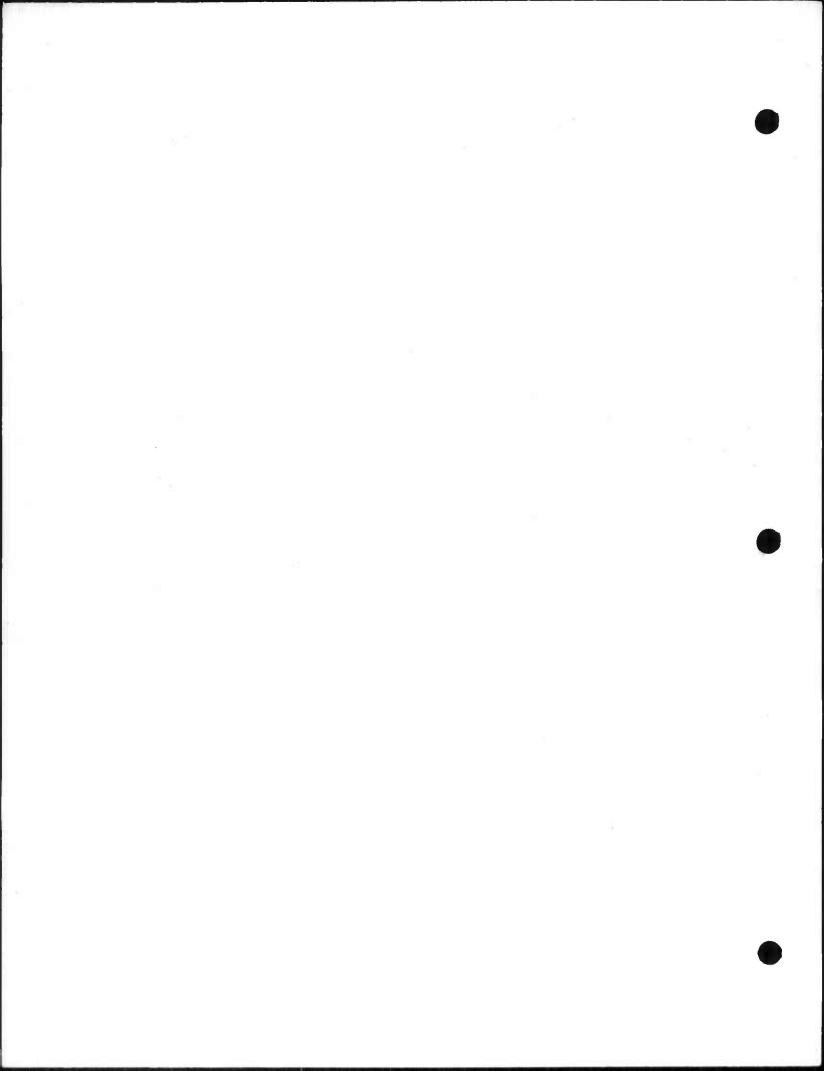
31. Data fited (Month, Day, Year) 32. Registrer's Signatura Jala Davilson Revolate JAN 24 1996

30. Nama and addrass of person who complated cause of death (Itam 23a) (Typa, Print)

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| | | HEGISTRAN | | | _ | CENI | IFICA | IE U | F DEA | I H | | REG. NO | | | |
|--|---------------|--|-----------------------|------------------------------|-----------------------------|---------------------------------|--|--|--|------------------|------------|---------------------------------|-------------------------------|------------|--|
| | 1 | 1. DECEOENT'S NAME (First, | | | | | | | | | 2. DATE | OF DEATH | AV | YEAR 3 | . TIME OF DEATH |
| | | | tha | Thom | 7000 | 7 | | | | | 1 | JANUARY 29 1996 8:309. | | | 8:309 " |
| | | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | | yrs. leet birtho | | DER 1 YEAR | | | 7. DATE | OF BIRTH | | BIRTHPL | ACE (State or Foreign |
| P | | 820-06-6445 | | 1 M 2 X F | 90 | 6 YR | B. MONTH | 6 DAYS | DAYS HOURS MR. (Month, Day, Year) Oct 26, 1899 Mar | | | | yland | | |
| pour | | 9e. FACILITY NAME (If not ins | | | | | 9b. C | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY C | | | | | | | |
| 1, 2, 3 should | O B | Shady Grove | Hospi | tal | | | | Roo | ckvil: | le | | | Montgomery | | |
| = | DIRECTOR | RESIDENCE OF DEC | | | | | | | | | | | | | |
| ě | 2 | | 10b. COUNTY | | | 10c. | 10c. CITY, TOWN OR LOCATION | | | | | | | 10 | Od. INSIDE CITY |
| nit. | | Maryland | INOI | ntgomery | | | | iditi | nersbu | ırg | | | 1 🗆 YES 2 🛭 | | |
| physician. burial-transit permit. Pages | FUNERAL | 10e. STREET AND NUMBER | A | | | | | - 1 | 10f. ZIP COD | | _ | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| in. | | 301 Russell | Avenu | ie | | | 20877 | | | | | USA | | | |
| ysick | | 11. MARITAL STATUS 1 Never Merried 2 1 | | 12. WAS DECEDEN FORCES? 1 | | | 1 | 3. WAS D | ECENDENT (| OF HISPAN | NIC ORION | N? (Specify Yes | or No- | 4. RACE - | - American Indian, White, etc. |
| D 20 | B | 3 Wildowed 4 Divon | | IF YES, OIVE V | | | NO If yes, specify Cuben, Mexican, Puerto Ricen 1 YES 2 X NO Specify: | | | | | ricon, etc.) | | Specify: | |
| r attending use as the | ED | ^ | DENT'S EDUC | | | | 117.0 | | | | | | White | | |
| use at | ETE | (Specify only | highest grade | | | (Give kind | | ne during i | TION most of worki | ng | 166 | . KIND OF BUS | BINESS/INDUS | STRY | |
| oital o | ا ۾ ا | Elementary/Secondary (0- | 12) | College (1-4 or 5 | +) | | | , | | | | - | Num IIa | | |
| the hospit detached once. | COMPL | 17. FATHER'S NAME (First, Mic | della diamin | | | <u> </u> | Housewife Own Home 18. MOTHER'S NAME (First, Middle, Mailden Surneme) | | | | | | | | |
| be de | | Joseph Walte | | h | | | | | | | | | | no++ | |
| should t | 띪 | Joseph Walter Smith Florence Elizabeth Bennett | | | | | | | | | | | | | |
| should 5 should | 2 | | 19b. MAIL | NO ADDRI | SS (Stree | and Number | or Rural F | Floute Num | ber, City or Town | n, State, Zip Co | MID O | 1206 | | | |
| ay be | | Charles R. Thompson 500 Virginia Ave, Apt 1403, Towson, MD 21286 20a. METHOD OF DISPOSITION DATE 20b. PLACE AND DATE 20b. PLACE AND DATE 20b. LOCATION — City of Town, State | | | | | | | | | | | | | |
| hours after death. Page 6 may be retained by the hospital or attending physician, bd in by the funeral director, page 5 should be detached for use as the burial-tran or remonal, medical examiner must be notified at once. | | 1 X Buriel 2 Cremetion | 3 🗆 Remo | val from State | 20b. P | PLACEAND DA Lery, crampatory | TEOF DISP | OSITION/ | Name of | | DAT | | | | |
| director, er must | | 1 Surface 2 Cremetton 3 Removal from State Competery, cremetory or other place The Carmet Cemetery 2/1 Parkton, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eline Funeral Home | | | | | | | | | | | | | |
| death. Pag tuneral di I. examiner | | an diditations of traverage | SERVICE LICI | // | . / | 2 | 2 | | | | | | | | |
| T de | | 1 ander | 111 | · / le | M | 25 | | 934 | S. Ma | ain S | St, F | lampste | ead, M | D 21 | 074 |
| hours after ded in by the or removal, medical e | | 23. PART I. Enter the dis | eesea, or c | omplications tha | t coused t | the deeth. E | o not ent | er the m | node of dy | ing, eucl | h ae care | diec or reepi | ratory arrea | ıt, | Approximate |
| | | IMMEDIATE CAUSE (Fina | | lat only one cau | se on aac | ch iina. | 1 | | | , , | | | | | Interval Batween Onset end Death |
| | li | disease or condition | | Cim | west | 0 | lana. | . 1 | 6 | 1,0 | k | | | | 34 hours |
| completely ial, cremati event, t | | rasumy in death) | | DUE TO | (OR AS A C | CONSEQUENC | OF): | | 7 | / | (| | | | -4.2013 |
| and corr burial, matic en | z | | | 81 | rle | Pin | us | Su | und | ven | ne | - | | | 11 month |
| 8 " o F | CERTIFICATION | Sequentially list condition if any, leading to immediate | | DUE TO | (OR AS A C | ONSEQUENC | OF): | | 0.0. | | | | | | |
| ysicia prior | S | cause. Enter UNDERLYIN CAUSE (Disease or Injury | G | | | | | | | | | | | | |
| rtifica ng ph jiene | 드 | that initiated events | | DUE TO | (OR AS A C | CONSEQUENC | OF): | | | | | | | | |
| he death certificate be the attending physician Mental Hygiene prior b Ijury, or other traur | ᇤ | resulting in death) LAST | d | | | | | | | | | | | | |
| death demta | | PART II Other elections | t conditions | a a mandh coal m a A a | 4 | | | | | | | | | | |
| by the | EDICAL | PART II. Other eignifican | Condition | contributing to | daath but | t not remulti | g in tha | undariyi | ng cause (| given in | Part I. | 24s. WAS AN PERFOR | | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| es th alth | ă | | | | | | | | | | | 1 TYES 2 | NO | | OMPLETION DF CAUSE F DEATH? |
| equir en si of He how | Σ | | | | | | | | | | _ / | | K | 1 | ☐ YES 2 P-NO |
| law rept. | ÿ | DID TOBACCO US | | IBUTE TO CA | | | | | | ERTAIN | 1 🖸 | | | | 71 |
| The ate h | SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | | HOSPITAL: | 26 | B. PLACE OF E | OTH | | D) | | | | | | |
| TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed writhin 72 hours after death with the State Dept. of Health and Mental Hygiene prior time WorkTANT: If Item 28 is marked, or Item 23 shows any injury, or other traus | YSI | 1 TYES 2 NO | | 1 Cinpetient 2 | ER/Outpet | lent 3 DO | | | me 5 🗆 Re | sidence | 6 🗆 Othe | r (Specify) | | | |
| HYSII his co | PHY | 27. MANNER OF OEATH 1 N Netural 5 P | | 28e. DATE OF (Month, D | | 28b. | TIME OF | | JURY AT | | 28d. OES | CRIBE HOW IN | JURY OCCUP | RED | |
| NG P | BY | | ending vestigation | | | | M | | YES 2 | NO | | | | | |
| BR: A | 0 | | ould not be | 26e. PLACE O building, | F INJURY — etc. (Specify | - At home, fer | n, atreet, fo | ectory, off | ice | | 26f. LOC. | ATION (Street a or Town, State) | nd Number or | Rural Rout | n Number, |
| ECTC TR aff | ETE | 4 Nomicide de | etermined | | | | | | | | | | | | |
| L Diff | PL | 290. CERTIFIER 1 CERTIF | YING PHYSIC | IAN: To the best of | my knowled | dge, death occ | urred at the | time, de | te end place, | end due | to the cau | se(s) end men | ner as stated. | | |
| SPITA VERA VIII 7 | COMPLE | | | | | | | | | | | | | | nd manner ee stated. |
| FTA WITH | S | 296. SIGNATURE AND TITLE C | F CERTIFIER | MO | | | | | 29c, LICE | NSE NUM | BER | | 29d, DATE S | IONED (M | onth. Day. Year) |
| 프트를 2 | ω | - Viu | mer | 1 | | | | | D | 112 | 2 2 | 2 | 10 | 40 2 | 30 1996 |
| FFA | 5 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAUS | SE OF DEAT | H (ITEM 27) (1 | pe, Print) _ | | 1 9 | 72 | the Court | | | 771 |) 0 |
| | | M. CHO | UDR | 4 /111 | 9 1 | | vill | e P | ike | | n | 10 | 20 | 85 | 2 |
| | i | 31. DATE FILED (Month, Day, Ye | ver) | 32. BEGISTRA | | URE | | - | | | | •) | 0.0 | | |
| | | FER - | 1 1996 | Julia D | huden | Rardal | | | | | | | | | |
| , L | | | بالترب | 1 | | | | | | | | | | | |



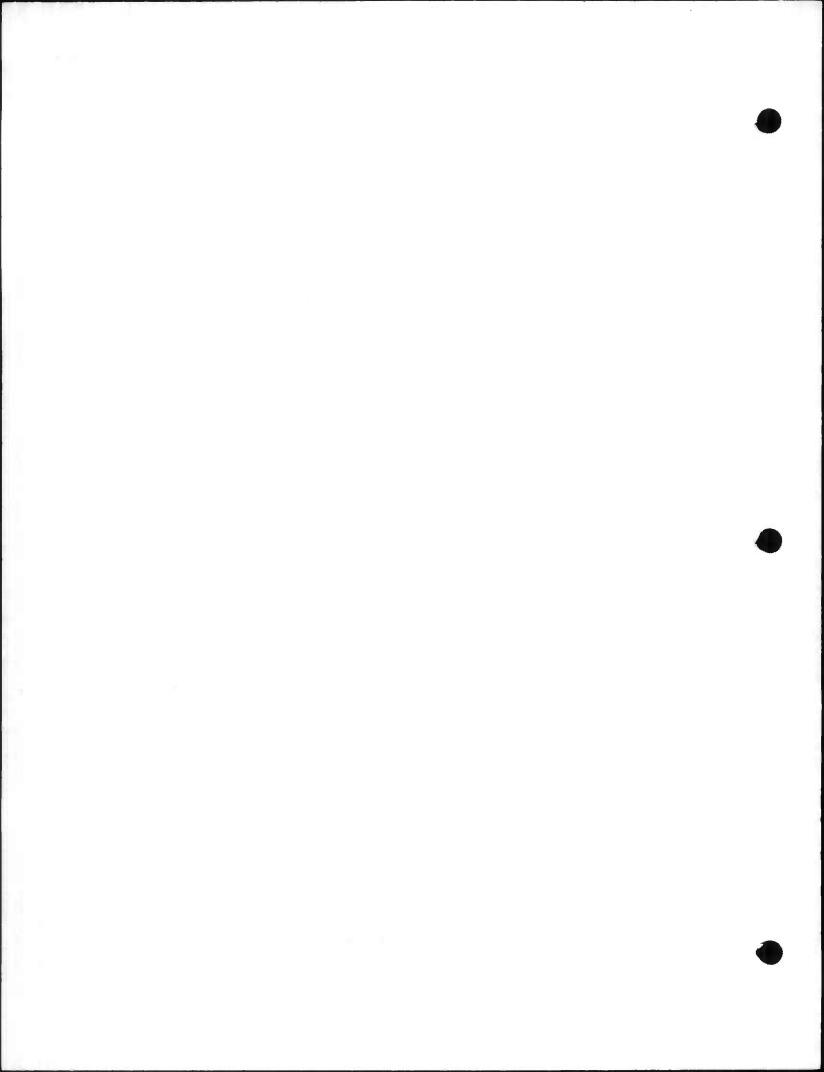
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fine death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | IENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIENE REG. NO. | 20010 |
|---------------|---|--|--|--|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | 3. TIME OF DEATH |
| 1 | SUSIE G | Thomas | 9n | | DAY DAY | TYEAR MINO |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | In yrs. lest birthday) IF | UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 6. BIRTHPLACE (State or Foreign |
| | 579-22-0165 | 1 □ M 2 💢 E | | THE DAYS HOURS MIN. | Month, Day, Year) | Country) |
| | 9a. FACILITY NAME (If not institution, give at | | 3 | | June 10, 191 | D MAYY/AND |
| 000 | | | | CITY, TOWN OR LOCATION OF D | | COUNTY OF DEATH |
| 0 | RESIDENCE OF DECEDENT | MONT, U. | 1/49e 0 | ATTHERSBURG | 8 | MONTGOMERY |
| <u> </u> | 10a. STATE 10b. COUNTY | | 10c CITY TO | OWN OR LOCATION | | |
| DIRECTOR | mo mo | VTGORER } | | 10011/10 | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | 70014-07 | 1/00 | | | 1X YES 2 NO |
| A A | | STREET | | 10f. ZIP CODE | | CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | | | 2085 | | 45.4. |
| 5 | 1 Never Married 2 Merried | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 XNO | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic | NIC ORIGIN? (Specify Yes or No | - 14. RACE — American Indian, Black, White, etc. |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 TYES 2 NO Speci | | Specifyery I |
| 03 | 15. DECEDENT'S EDUC | CATION | | | r | Black |
| | (Specify only highest grade | completed) | (Give kind of work life. Do NOT use rel | done during most of working | 16b. KIND OF BUSINESS | S/INDUSTRY |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | C001 | 10d.) | Naval N | lad Hachital |
| N N | 17. FATHER'S NAME (First, Middle, Last) | | COX | 7 | 1/40/01/10 | ea. TIUSPIKI |
| | In Patrick S Name (First, Micolo, Last) | 11.61 | | 18. MOTHER'S N | AME (First, Middle, Maiden Surnar | ne) |
| 出 | UIINO | WN | . 10 | UI UI | KNOWN | |
| 2 | 199 INFORMANT'S NAME (Type/Print) | laton day | 19 MAILING ADI | PRESS (Street and Number or Bural | Route Number, City or Toyth State | a, Zip Code) |
| | Juste Tireat | Jiep-gaugi | Mar) 215 | N. VAIN DUI | en St. Kuc | KVILLE, N. D.20850 |
| | 20a, METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Remo | oval from State Con | PLACE AND DATE OF DE | SPOSITION (Name of | PATE 20c. LOCATION | N — City or Town, Slate |
| | #☐ Donation 5 ☐ Other (Specify) | 4 / | Wark | Illem PK | MI LAU | irel, MD |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 1. | 22. NAME AND ADDRESS OF FA | | |
| | FERLY V. | TUBIL | 2011 | | JNERAL HOME | , P.A. |
| | 23. PART i. Enter/the diseases, or c | complications that cause | the death Do not | ROCKVILLE | MD 20850 | |
| | shock, or heart fallure. | List only one cause on e | ach line. | mer the mode of dying, suc | m as cardiac or reapiratory | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | 111.1 | 1 | ./ | | Onset and Death |
| 1 | resulting in death) | METED | Olicra | 114re | | 12 hours |
| | | DUE TO (OR AS A | CONSEQUENCE OF): | 1 1 1-1 | | |
| S | Sequentially list conditions, | conge | CONSEQUENCE OF: | art failu | re | 2 months |
| Ē | If any, leading to immediate cause. Enter UNDERLYING | DUE TOTOR AS A | CONSEQUENCE OF): | 1 -1 - 41 | 1 -1 |) |
| 길 | CAUSE (Disease or Injury | | 0195 CU | lar Allia | eng | of months |
| E | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | 3 | |
| CERTIFICATION | | l | | | | |
| AL C | PART II. Other significant conditions | s contributing to death b | ut not resulting in th | ie underlyling ceuse given in | Part I. 24e, WAS AN AUTOR | PSY 24b. WERE AUTOPSY FINDINGS |
| | Vidhetes | Melli | tus | , | PERFORMED? | AWAILABLE PRIOR TO |
| MEDIC | | 770000 | -4 | | 1 TYES 2 52 NO | OF DEATH? |
| | DID TOPACCO LICE CONTENT | NOTICE TO CALLES | | | | 1 TYES ZNO NO |
| PHYSICIAN: | DID TOBACCO USE CONTR | | | | N.B. | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH (C | heck only one) HER: | | |
| YS | 1 TES 2 NO | 1 Inpatient 2 ER/Outp | | Nursing Home 5 - Residence | 6 Other (Specify) | |
| H | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY | OCCURED |
| B | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 YES 2 NO | | |
| ED I | 3 Suicide 6 Could not be | 28a. PLACE OF INJURY building, atc. (Spec | - At home, ferm, street | , factory, office | 281. LOCATION (Street and Nui City or Town, State) | mber or Rural Route Number, |
| | 4 Homicide determined | | ,, | | Only or lown, State) | |
| COMPLET | 29a. CERTIFIER Check only | CIAN: To the best of my know | edge, death occurred at | the time, data and place, and due | to the cause(s) and manner as | atelad |
| N N | | | | | | to the cause(a) and manner so stated. |
| | 291. SIGNATURE AND TITLE OF CERTIFIER | | | | | |
| 8 | 01 1 1 1 1 | 1 1 | MA | 29c. LICENSE NU | 29d. | DATE SIGNED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | 100010 | 1/1/ | 14450 | 5 3 5 1 | 1-27-96 |
| | A C / C AME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | THE (ITEM 27) (Type, Print | 1 | -11 -1 | un I norm |
| | Manie Drown | 0,41221 | OTHBUS | 411/100,09 | IMCISOURGE | MU 200/9 |
| | 31. DATE FILED (Month, Day, Year) | 32. AEGISTRAR'S SIGN | ATURES / | | N | |
| | JAN 31 1996 | Java a mores | - Address | | | |
| | ^ | | | | | |



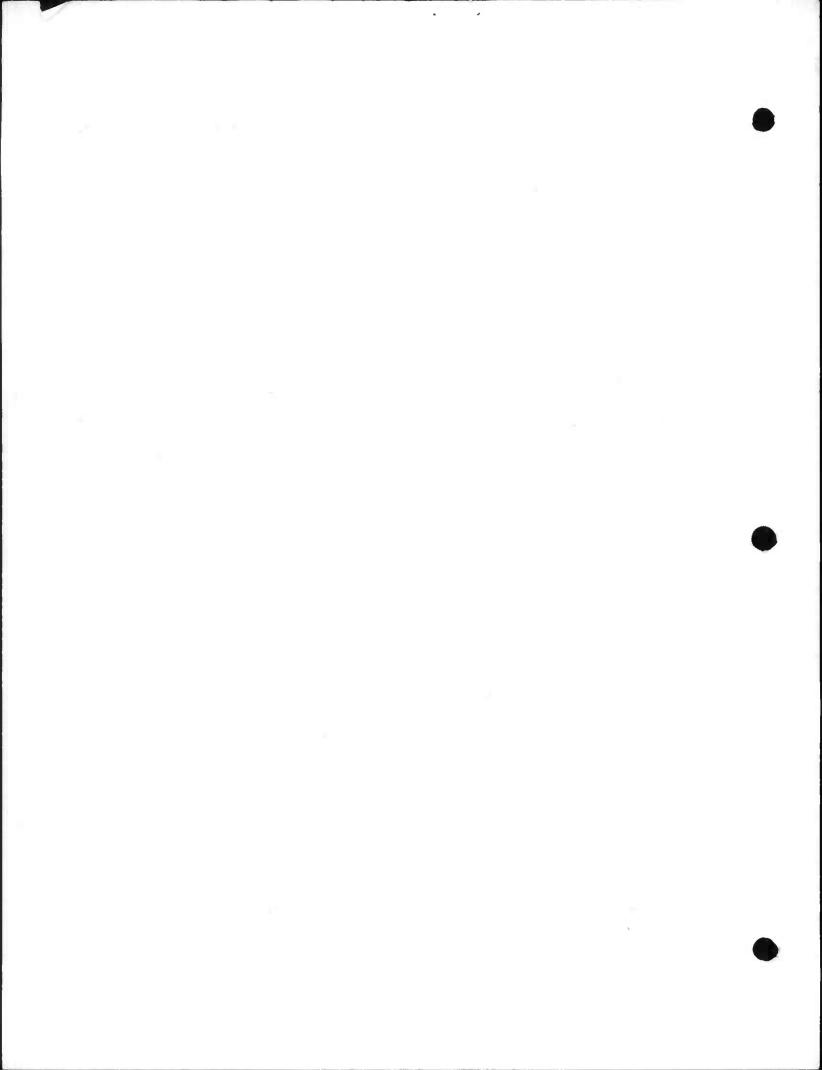
BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | | | | |
|--|---|--|---------------------|---------------------|---|-----------------|--|--|--|
| 1. OECEDENT'S NAME (First, Middle, Last) | | | | BEATTI | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| Theresa | G. Ventre | | | | MONTH D | 3, 1996 | AR . | | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | IRTHPLACE (State or Foreign | | |
| 170 - 34 - 5776 | 1 M 2 X F 9 | O YAS. | ONTHS DAYS | HOURS MIN. | Aug 17, 19 | C | ountry) | | |
| 9a. FACILITY NAME (If not institution, give | street and number) | 9 | L CITY, TOWN | OR LOCATION OF D | | 9c. COUNTY C | Pennsylvania | | |
| Allegis Nursing 1 | Home | | Kensir | | | | | | |
| RESIDENCE OF DECEDENT | | | Kensti | igcon | | Monte | gomery | | |
| 10e. STATE 10b. COUNT | | 25.77 | OWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? | | |
| Maryland Monte | gomery | Ken | singtor | 1 | | | 11 YES 2 NO | | |
| 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | 10g. CITIZEN (| OF WHAT COUNTRY? | | |
| 300 McComas Aven | ue | | | 2090 | 2 | U.S | S.A. | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? 1 YES | | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specify Yes | or No- 14. F | RACE — American Indian, Black, White, etc. | | |
| 1 Never Married 2 Married 3XXWidowed 4 Divorced | IF YES, GIVE WAR OR O | | | ZXNO Speci | | | Specify: White | | |
| 15, DECEDENT'S EDU | 1 | | <u> </u> | | | | | | |
| (Specify only highest grade | e completed) | 18a. DECEDENT'S US (Give kind of work life. Do NOT use n | done during mo | ON st of working | 16b, KIND OF BUS | SINESS/INDUSTR | RY | | |
| Elementery/Secondary (0-12) | College (1-4 or 5+) | homema | | | own ho | ome | | | |
| 17. FATHER'S NAME (First, Middle, Last) | 4 years | | | | | 100.00 | | | |
| Frank Grippi | | | | l . | AME (First, Middle, Malden | , | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | hine Valve | | | | |
| | | 1 | | | Route Number, City or Tow | | | | |
| Frances Ventre | | | | | Silver Spr | | | | |
| 20s. METHOD OF DISPOSITION 1 Disposition 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | |
| 4 Donation 5 Other (Specify) Holy Cross Cemetery/Jan. 27, 1996 Old Forge, Pa. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | | uneral Home | P.A. | | | |
| Treves. | - A | | | | Avenue La | | Md. 20707 | | |
| 23. PART I. Enter the diseases, or | complications that ceused | the death. Do not | entar the mo | de of dying, suc | th as cerdiac or respi | ratory arrest, | Approximate | | |
| IMMEDIATE CAUSE (Final | List only one ceuse on a | ech lina. | | | | | Interval Batween Onset and Death | | |
| disease or condition | ASDIPM | -112X1 + | NEUN | MINOL | | | Warre | | |
| resulting in death) | DUE TO (OR AS / | CONSEQUENCE OF): | 10000 | 70/0/11 | | | WEEKS | | |
| | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| cause. Enter UNDERLYING | C. | | | | | | | | |
| CAUSE (Disease or injury that initieted events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| resulting in death) LAST | d | | | | | | | | |
| PART If Other algolficant condition | no consultante e de est t | | | | | | | | |
| PART It. Other algnificant condition ALL HEI MEOL'S | DISEASE | ut not resulting in t | he underlying | ceuse given in | Part I. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | |
| 1 | | | | | 1 YES 2 | ID NO | COMPLETION DF CAUSE OF DEATH? | | |
| HYPOTHYRE | | | | | | | 1 - YES 2 - NO | | |
| DID TOBACCO USE CONT | RIBUTE TO CAUSE O | F DEATH YES | | UNCERTAI | N 🗹 | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH (| Check only one) | | | | | | |
| 1 TES 2 THO | 1 Inpetient 2 ER/Outp | | | e 5 🗆 Residence | 6 Other (Specify) | | | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJ | URY AT | 28d. OESCRIBE HOW II | NJURY OCCURED | | | |
| 1 Antitural 5 Pending 2 Accident Investigation | | | | ES 2 NO | | | | | |
| 3 Suicide 6 Could not be | 28a. PLACE OF INJURY building, etc. (Spec | - At home, farm, street | et, factory, office | | 261. LOCATION (Street a City or Town, State) | nd Number or Ru | rel Route Number, | | |
| 4 Homicide datermined | | | | | only or lown, ording | | | | |
| 29a. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the beat of my know | edge, death occurred a | t the time, date | end place, and due | to the cause(s) and man | ner as stated. | | | |
| | ER: On the basis of examination | | | | | | se(s) and manner as stated. | | |
| 196/SIGNATURE AND PITTE OF CERTIFIE | | | | | | | | | |
| 29c. LICENSE NUMBER 29d. DATE SIGNEO (Mprith, Day, Year) | | | | | | | | | |
| 39/NAME AND ADDRESS OF PERSON WI | O COMPLETED CAUSE DE DE | ATH (ITEM 27) | nt) | 1000 | 70 | 1/2 | 7/70 | | |
| 1/ /1100/5 D. | 39, NAME AND ADDRESS OF PENSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) 17990. Print) | | | | | | | | |
| 31, DATE FILEO (Month, Day Mear) | 1 4 6 L O D | ATURE 0 | LVAII | - Lt , 1' | 110 · 9-10 8 | 58 | | | |
| JAN 2 5 199 | 16 Julia David | sor Rand-11 | | | | | | | |



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| DSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | INERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burkal, cremation, or removal. | PORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|--|
| THE HOSPIT | THE FUNERA | 7 filed within 7 | MPORTANT: 1 |

| FOR | | CTATE OF B | AADVI AND | / DEDAR | THEFAIT (|)E 1151 | | | | _ | 0 | 03012 |
|--|--------------------------|--------------------|---------------------------------|----------------|--|-----------|------------------------|------------|------------------------------------|-------------|-----------------|---|
| 1 - STATE REGISTRAR | | STATE OF I | | | ICATE | | | MENIA | REG. NO. | E . | | |
| 1. DECEDENT'S NAME (First | 1000-0-5 | LOU | rse | • | W | est | and . | MONT | | | 996 | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUM | | 5. SEX | B. AGE (In yrs. I | last birthday) | IF UNDER 1 Y | EAR I | F UNDER 24 HRS. | 7. DATE | OF BIRTH | OCE, / | 0. BIRTH | PLACE (State or Foreign |
| 214-12-659 | 6 | 1 🗆 M 2 💢 F | 73 | YRS. | MONTHS D | MYS H | OURS MIN. | Aua | th, Day, Year) | 1922 | Mar | vland |
| 90. FACILITY NAME (If not in PENINSULA | | | I CENT | FR | | LISI | LOCATION OF D | EATN | | 9c. COU | NTY OF DE | ATH |
| RESIDENCE OF DE | | AL FEDICA | AL CENT | LIK | 02. | | | | | | | |
| 10e. STATE | 10b. COUNTY | r | | 10c. CIT | Y, TOWN OR | LOCATION | N | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland | | erset | | Pri | ncess | Y | | | | | | 1 TES 2 NO |
| 10611 PERI | • | TN CUUDCI | LDOAD | | | | P CODE | | | 10g. CIT | | THAT COUNTRY? |
| 11. MARITAL STATUS | TITAWN. | 12. WAS DECEDEN | IT EVER IN U.S. | | 13. WA | | 21853 DENT OF HISPA | NIC ORIGI | N? (Specify Yes | or No- | U.S | - American Indian. |
| 1 Never Merried 2 3 State 3 St | | FORCES? 1 | YES 2 NAR OR DATES | € NO | | | ly Cuben, Mexico | | Ricen, etc.) | | Black Specif | , White, etc. |
| | | <u> </u> | - | | | | | | | | | WHITE |
| (Specify on | CEDENT'S EDU | completed) | | | USUAL OCCI work done duri se retired.) | | of working | 16 | b. KIND OF BU | SINESS/IN | DUSTRY | |
| Elementary/Secondary (| (0-12) | College (1-4 or 5 | | OUSEW | TEE | | | | OWN H | OME | | |
| 17. FATHER'S NAME (First, A | | | | | | 1 | B. MOTNER'S N | ME (First, | | | | |
| HENRY CLA | | WAY | | | | | MARY EL | | | | | |
| WALTER L. | | CD | | | | | Number or Rural | | | | | 21853 |
| 20e. METHOD OF DISPOSIT | TION | | | | OF DISPOSITI | | | HUH | | | City or To | NNE, MD. |
| 1 Buriel 2 Cremeti 4 Donation 8 Othe | | oval from State | | | TIST C | | | 1 | 11111 | | KE CI | |
| 21, SIGNATURE OF FUNER | AL SERVICE LIC | CENSEE / | ^ | | 22. NA | ME AND | ADDRESS OF FA | CILITY | | 001101 | <u> </u> | 11, 110. |
| * Chan | 2124 | 16nn |) MOO: | 295 | | | FUNER OMERSET | | | C ANN | E MD | 21051 |
| 23. PAST Enter the cahock, or it immediate CAUSE (FI disease or condition resulting in death) | heert fellure. | List only one car | of caused the use on each if | ne. | | ne mode | of dying, suc | ch ss cs | disc or resp | Iratory si | rest, | Approximata interval Between Onset and Death |
| Sequentially list condi- if any, leading to immo cause. Enter UNDERLY CAUSE (Disease or inj- that initiated events resulting in death) LA: | ediate ring ury | c. DUE TO | OR AS A CONS | SEQUENCE O | sucer F): | | | | | | | 4d 5d |
| | | <u> </u> | hrotic. | | | | | | | - | | 1 |
| PART ii. Other signific | | getire W | 4 | t resulting | in the unde | erlying o | euse given in | Part i. | 24a. WAS AN PERFOI 1 YES 2 | RMED? | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO |
| DID TOBACCO U | USE CONT | RIBUTE TO CA | AUSE OF DE | ATH Y | ES 🗆 N | 02 | UNCERTAI | N | | | | |
| 25. WAS CASE REFERRED EXAMINER? | TO MEDICAL | HOSPITAL: | | | TN (Check onl | ly one) | | | | | | |
| 1 YES 2 ANO | | 1 Finpatient 2 | | 3 🗆 DOA | 4 🗆 Nursin | 8c. INJUR | 5 Residence | | er (Specify) | IN HIERY CO | CHIBER | |
| 1 Netural 5 | Pending Investigation | (Month, i | Day, Year) | | JURY M | WORK | (7 | 290.08 | QUINDE NUM | INDUST OF | ~UNEU | |
| 2 Accident 3 Suicide 8 Homicide | Could not be determined | | OF INJURY — At , etc. (Specify) | home, farm, | street, tectory | y, office | | | CATION (Street y or Town, Stere | | or or Aural F | loute Number, |
| onel | | ER: On the best of | | | | | | | | | |) end manner ee stated. |
| 2919 SIGNATURE AND TITLE | FOF CERTIFIE | R | | | | 2 | 9c. LICENSE NU | MBER | | | / | (Month, Day, Year) |
| Milly A | hule | 24 m | 0 | | | | 0082 | -11 | | • | 1/2 | 8/46 |
| Philip & | F PERSON WE | 10 COMPLETED CAL | - 145 | | | ST | . SA4: | SBUP | ey M D | 218 | 01 | |
| 31. DATE FILE AND | 0~1996 | JUL 9010 | ABLE SIGN THE | dell | | | | | | | | |

Tables or est

| | , 3 should | | |
|---|---|---------------------|---|
| | 1,2 | | |
| | Pages | | |
| physician. | kigned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | | |
| or attending | w use as the | | |
| une mospinal | e detached fo | | t once. |
| ye o may be retained by the mos | 5 should b | | is any injury, or other traumatic event, the medical examiner must be notified at once. |
| 33 62 | page | | þ |
| 0 00 | rector, | | must |
| Dean, ra | funeral d | | examine |
| ate of executed within £4 india artel Ucaul, ragi | ed in by the | or removal | medical |
| 1111 E-1 | tely fille | nation, | t. the |
| 20 410 | omple | al, crei | even |
| CASCUL | and o | to buri | matic |
| יפוב חב | hysicial | prior : | ir frau |
| COLUMN | ding p | hygiene | r othe |
| line of | atten | ealth and Mental Hy | 0 % |
| 22 | the / | d Me | Inini |
| nar. | ed by | th an | anv |
| B | ě | eat | 95 |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | |
|---|--|--|--|----------------------|---------------------------|------------|------------------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | | | 3. TIME OF DEATH | | | |
| | ALBERT WILSON | | | | | JANUA | RY 24 | 1996 | 8:05 P. M | | | |
| | 034-03-3200 ¹XX ^{M 2 □ F} | | | | | | | 8. BIRTHPLACE (State or Foreign BOSTON, Ma | | | | |
| DIRECTOR | 9a. FACILITY NAME (If not institution, give street and number) MALCOLM GROW USAF MEDICAL (RESIDENCE OF DECEDENT | CENTER | | CLINTON | R LOCATION OF DE | ATH | | PRINCI | OF DEATH E GEORGES | | | |
| 5 | 10a. STATE 10b. COUNTY | | | 1.44 | | | | | 10d. INSIDE CITY | | | |
| ā | Maryland Prince Georg | ge's | C | Clinton | | | | | 1 TES 2 NO | | | |
| FUNERAL | 10505 Mullikin Drive | | | 101. | 20735 | | | | d States | | | |
| B | 11. MARITAL STATUS | VER IN U.S. ARI YES 2 N OR DATES | U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. If yea, specify Cuban, Maxican, Puerto Rican, stc.) | | | | | | RACE — American Indian, Black, While, alc. Specify: White | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | TRY | | | | | | | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) 12th | st of working sman | Metropolitan Life | | | | | | | | | |
| 00 | 17. FATHER'S NAME (First, Middle, Lest) | | | | | | | | | | | |
| BE | Frank E. Wilson | Christin | | | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) 19b. MalLing address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 105.05 Mullikin Drive, Clinton, Maryland 20735 | | | | | | | | | | | |
| | 200. METHOD OF DISPOSITION 1 Burlel 2XX Cremetion 3 Removel from State 4 Donetton 5 Other (Specify) 200. PLACE ANDDATE OF DISPOSITION (Name of Clinton, Md | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. NAME AN | D ADDRESS OF FAC | | | | me, Inc 6633 | | | |
| old Alexandria Ferry Road, Clinton, Md 20 | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition and disease or condition | | | | | | | | | | | |
| _ | RENAL FAILURE | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| S | CAUSE (Disease or Injury C. DISSEMIN. | ATED IN | | SCULAR | COAGULAT | CION | | | | | | |
| Ë | resulting in deeth) I AST | | | TETO | | | | | i | | | |
| | d. CHRONIC | | | | | | | | | | | |
| A | PART ii. Other significant conditions contributing to de | ath but not re | esulting in | the underlying | cause given in | | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| PHYSICIAN: MEDIC | LEFT LOWER LOBE PNEUMONIA | | | | | - 1 | YES 2 | XNO | OF DEATH? | | | |
| Σ. | DID TOBACCO USE CONTRIBUTE TO CAUS | SE OF DEA | TH YES | | UNCERTAIN | 10 | | | 1 YES 2 NO | | | |
| X | 25. WAS CASE REFERRED TO MEDICAL | | | (Check only one) | | | | | | | | |
| SIC | 1 YES 2 KNO HOSPITAL: | 9/Oulpatient 3 | □ DOA 4 | OTHER: | e 5 🗆 Residence | 8 Other (S | Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATH 28a. DATE OF IN. (Month, Day. 2 Accident investigation | IURY Year) | 28b. TIME (| WO WO | URY AT RK? 'ES 2 NO | 28d, DESCR | NBE HOW IF | NURY OCCUR | ED | | | |
| | 3 Suicide 8 Could not be 4 Homicide 8 determined | JURY — Al hou. (Specify) | me, farm, atre | eet, factory, office | | | ON (Street a Town, State) | nd Number or i | Rural Route Number, | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER; On the best of my | | | | | | | | suse(s) and manner as stated. | | | |
| H | 29b. SIGNATURE AND TITLE OF CENTRISH | | | 29c. LICENSE NUN | IBER | | • | ARY 24 1996 | | | | |
| 2 | 30. NAME AND ADDRESS OF PESSON WHO COMPLETED CAUSE | Line and | 4 27) (Type, Pi | rint) 1050 | WEST PE | | |) | | | | |
| | LARRY N. JOHNSON, MAJ, USAF | | | ANDF | REWS AFB | MD 2 | 0762- | -6600 | | | | |
| | 31. DATE FILED (Mooth, Day, Year) 1996 32. REGISTRAR'S | BUCLER | Cardall. | | | | | | | | | |

| DIVISION OF VITAL RECORDS, P.O. BOX 68/00 BALLIMORE, MARTLAND ZIZIS-0020 | O THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|---|---|
| DIVISION OF V | TO THE HOSPITAL DR ATTENDING PHYSICIA | TO THE FUNERAL DIRECTOR: After this certif be filed within 72 hours after death with the | IMPORTANT: If Item 28 is marked, or |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | | | MENTAL HYGI REG. | | | | | | |
|---------------|--|---------------------------------------|-----------------------|------------------------|----------------------------|---|---------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) INARGUL | Cati | nerine, | KER | | 2. DATE OF DEATH | DAY Y | 3. TIME OF DEATH 26 01-55 M | | | | |
| | 4. SOCIAL SECURITY NUMBER 5 | | yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Yes | 6. | BIRTNPLACE (State or Foreign Country) | | | | |
| | | □ M 3xx 76 | | ONTHS DAYS | HOURS MIN. | Feb 22 1 | 919 W | ashington DC | | | | |
| œ | 9a-FACILITY NAME (If not institution, give stree | | ~ | b. CITY, TOWN C | PLOCATION OF DE | ATH | | Y OF DEATN | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | my/AND HO | SPITHL | | HINTO. | √ | PMI | NEX- GEONGE | | | | |
| BE | 10s. STATE 10b. COUNTY | | 10c. CITY, | CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | | |
| | Maryland Prince | George | For | estvill | ZIP CODE | | Lavane | 1 TES 2 MYO | | | | |
| FUNERAL | 2558 Oak Glen Way | | | 101 | 20747 | | 1.0 | N OF WHAT COUNTRY? | | | | |
| 3 | | 2. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | | ENDENT OF HISPAN | IIC ORIGIN? (Specif | Yea or No- 14 | d States I. RACE — American Indian, | | | | |
| BY F | 1 Never Married 2 Married 3 X Widowed 4 Divorced | IF YES, GIVE WAR OR DAT | ES (CLANO | | 2 NO Specify | n, Puerto Rican, atc | .) | Black, White, alc. Specify: | | | | |
| | 15. DECEDENT'S EDUCAT | TION T | 18a. DECEDENT'S US | 1 | | This wine or | BUSINESS/INDUS | White | | | | |
| COMPLETED | (Specify only highest grade cor | mpleted) | (Give kind of wor | BUSINESS/INDUS | STRY | | | | | | | |
| 교 | 12th | College (1-4 or 5+) | Mailing | Clerk | | Lette | ring Sei | rvice | | | | |
| S S | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTNER'S NAME (First, Middle, Maiden Surname) | | | | | | |
| BE (| Albert Booth | | | | Gertrud | le E. Pad | gett | | | | | |
| 6 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | |
| | Lloyd Larry Walker, Sr. 1120 Amherst Ave Fredericksburg, Virginia 22405 206, METHOD OF DISPOSITION DATE 20c. LOCATION — City or Town, State | | | | | | | | | | | |
| | 1 X Burtal 2 Cremation 3 Remove 4 Donation 6 Other (Specify) | | | | | | | , Maryland | | | | |
| | 21. SIGNATURE OF PINERAL SERVICE LICEN | | | 22. NAME AF | ID ADDRESS OF FA | outlee Fu | neral Ho | ome, Inc 6633 | | | | |
| | × 6.118 | rot 1x | | Old A | lexandri | a Ferry | Rd, Clir | nton, Md 20735 | | | | |
| _ | 23. PART / Enter the diseases, or both | nplicetions that edused | The deeth. Do no | t anter the mo | de of dying, suc | h as cardiac or r | eapiratory arres | it, Approximate | | | | |
| | shock, or heart fellure. Lis IMMEDIATE CAUSE (Finel | it only one ceuse on ea | ch line. | | | | | Interval Between Onset and Death | | | | |
| | disease or condition - e. END STAGE COPD 100 | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| NO. | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| ATI | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| 임 | CAUSE (Disease or injury that initieted events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | |
| | PART II. Other significent conditions | contributing to deeth bu | t not resulting in | the underlyin | cause given in | Part I. 24s. WA | S AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | |
| CAL | HTN | | | | | PE | RFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| MEDIC | CAD | | | | | _ ''' | :5 2 2 1 no | OF DEATH? | | | | |
| ž | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF | DEATH YES | □ NO □ | UNCERTAI | N 🗆 | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | 6. PLACE OF DEATH | (Check only one) | | | | | | | | |
| YSI | 1 VES 2 NO 1 | Inpatient 2 ER/Outpa | tient 3 DOA 4 | ☐ Nursing Non | | 8 C Other (Specify | | | | | | |
| | 27. MANNER OF DEATN 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME INJU | PY WC | URY AT PRK? YES 2 ND | 28d. DESCRIBE H | OW INJURY OCCU | RED | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could get be | 28e. PLACE OF INJURY | – At homa, farm, str | | | 281, LOCATION (S | treet and Number or | Rural Route Number, | | | | |
| COMPLETED | 4 Nomicide 6 Could not be determined | building, atc. (Special | (y) | | | City or Town, | State) | | | | | |
| Ë | 29e. CERTIFIER (Check only | AN: To the best of my knowle | dge, death occurred | at the time, date | and place, and due | to the cause(a) end | menner as stated | | | | | |
| OM | and and | | | | | | | cause(a) and menner as stated. | | | | |
| Ü | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NU | | | SIGNED (Month, Day, Year) | | | | |
| TO B | SMC. | | | | 046 | 478 | > 1 | -23-96 | | | | |
| ř | 30. NAME AND ADDRESS OF PERSON WHO | Patel MID | TN (ITEM 27) (Type, F | irratts | Rd # 2 | 02 dr | nten | mD20735 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | | | 1, 50 | | | | | | |
| | JAN 3 0 1996 | Shir. Maure | son Randall | | | | | | | | | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

| | REGISTRAR | | CE | ERTIF | ICATE OF | DEATH | REG. NO | | | | | |
|--|--|--|---------------------|-------------|----------------------|--------------------|---|-------------------|--|--|--|--|
| , | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | 2. OATE OF DEATH | AY YEAR | 3. TIME OF DEATH | | | |
| ľ | WILLIAM WHITE | | | | | | JANUARY 2 | | 1153 PM | | | |
| - 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | B. AGE (In yrs. les | t birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | a. BIF | RTHPLACE (State or Foreign | | | |
| Di. | 426-42-4876 | 1X M 2 🗆 F | 6 | 7 YRS. | MONTHS DAYS | HOURS MIN. | JANUARY 1 | | MISSISSIPPI | | | |
| - 1 | 9a. FACILITY NAME (If not institution, give : | street and number) | | | 9b. CITY, TOWH (| OR LOCATION OF DE | | 9c. COUNTY OF | | | | |
| ۳ ا | MALCOLM GROW MED | ICAL CENTI | ER | | CAMP S | PRINGS | | PRINCE | E GEORGE'S | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| # | 10a. STATE 10b. COUNT | - | | | Y, TOWN OR LOCA | | | | 10d. INSIDE CITY LIMITS? | | | |
| | - 4 | nce George | s' | 1.6 | mple Hil | TS | | | 1 TYES 2 NO | | | |
| ₹∥ | 10e. STREET AND NUMBER | | | | 10 | . ZIP CODE | | | F WHAT COUNTRY? | | | |
| | 3601 Farness Co | ırt | | | | 20748 | United States | | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT FORCES? 11 | | | | | NIC ORIGIN? (Specify Ye | n or No — 14. R/ | ACE — American Indian, lack, White, atc. | | | |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WA | R OR DATES | | 1 TYES | XX NO Specifi | in, Puerto Ricen, etc.) | Sp | pecify: | | | |
| | | | | | | | | | | | | |
| # | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | | | 1 | | | |
| 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. AIR FORCE Ret. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) | | | | | | | | -n+ | | | | |
| Ž | 17. FATHER'S NAME (First, Middle, Last) | | 0.1 | J. 211 | 11 10100 | | | | 7900 | | | |
| | Charles M. White | | | | | B . | ME (First, Middle, Maider La Ann For | , | | | | |
| B | 19a. INFORMANT'S NAME (Type/Print) | | 40 | h Bead this | 1000000 | | Route Number, City or Tox | | | | | |
| 2 | Gloria M. White | | | | | | emple Hill | | | | | |
| ł | | | | | | | , 1996 20c. LO | | | | | |
| | 20. METHOD OF DISPOSITION 12. Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify) | noval from State | | | | Cemeter | | | Virginia | | | |
| 1 | 21. SIGNATURE OF FUNEBAL SERVICE LI | CENSEE | r II a a a a | 90011 | | | - | - | ome, Inc 6633 | | | |
| | WAR A | 7 | | | | | | | on, Md 20735 | | | |
| | Fills | | | | | | | | , | | | |
| | 23. PART i Enter the diseases, or shock, or heart fellure. | complicatione that List only one caus | caused the de | eth. Do i | not enter the mo | de of dying, suc | h ss cardiac or resp | Iratory srrest, | Approximats Interval Between | | | |
| ļ | IMMEDIATE CAUSE (Fine) | , | | | | | | | Onset and Death | | | |
| | disesse or condition resulting in death) | CARDIAC | ARRES' | T VEN | TRICULA | R ARRYTH | MIA | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| Š | Sequentially list conditions, Due to (on as a consequence of): | | | | | | | | | | | |
| RTIFICATION | If any, leading to immediate couse. Enter UNDERLYING | 002 10 (0 | UH AS A CUNSE | OUENCE O | r): | | | | | | | |
| 2 | CAUSE (Disease or injury | c. DUE TO (| OR AS A CONSE | QUENCE O | Fh: | | | | | | | |
| | that initiated events resulting in death) LAST | | | | , | | | | j | | | |
| | | d | - | | | | | | | | | |
| 4 | PART II. Other significant condition | ns contributing to d | death but not | reculting | in the underlyin | g cause given in | | AUTOPSY 2 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| DICAL | | | | | | | 1½ YES | | COMPLETION OF CAUSE OF DEATH? | | | |
| ME | | | | | | | | | 1 TES 2 NO | | | |
| | DID TOBACCO USE CONT | RIBUTE TO CAL | JSE OF DEA | ATH YI | ES 🗆 NO 🗆 | UNCERTAI | N 🖾 | | | | | |
| ¥. | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLA | CE OF DEA | TH (Check only one) | | | | | | | |
| <u> </u> | 1 VES 2 NO | HOSPITAL: | ER/Outpatient 3 | DOA | OTHER: 4 Nursing Hon | ne 5 🗆 Residence | 8 Other (Specify) | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF II (Month, Day | | 26b. TIN | | JURY AT | 28d. DESCRIBE HOW | INJURY OCCURED | | | | |
| B | 1 XNatural 5 Pending 2 Accident Investigation | (3) | ,,, | | M 1 🗆 | | | | | | | |
| 3 Suicide 6 Could not be datermined 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28s. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | and Number or Rur | rel Route Number, | | | |
| | | | | | | | | | | | | |
| COMPLE | 29e. CERTIFIER (Check only 1 CERTIFYING PHYS | ICIAN: To the best of r | ny knowledge, de | eath occur | ed at the time, date | and place, and due | to the cause(a) and ma | nner as stated. | | | | |
| 8 | one) — | | | | | | | | se(a) and manner as stated. | | | |
| 20h CICNATURE AND TITLE OF CERTIFIED | | | | | | | | | NEO (Mooth Day Year) | | | |
| 8 | Tuday M | 1. Konn | 04 | | | 181784- | | | UARY 26 1996 | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | | | M 27) (Type | , Print) 1 | L TIPOR | DEDTMERE | | JAMES 20 1990 | | | |
| | AUDREY M. KERN, 1 | | | | 10 | | PERIMETER | | _ | | | |
| | | | | 0 | A | NUKEWS A | FB MD 207 | <u>0.00d</u> − 2d | | | | |
| Ì | 31. DATE FILED (MARY 30) 1996 32. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

DIVISION OF VITAL AL OR ATTENDING PHYSICIAN: The law L. DIRECTOR: After this certificate has 2 hours after death with the State Dep f. Nem. 28 is marked, or item 23 HOSPITAL FUNERAL I WITHIN 72 H TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

| BALTIMORE, MARYLAND 21215-0020 | he law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | e has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be be be to the atth and Mental Hygiene prior to burial, cremation, or removal. | c event, the medical examiner must be notified at once. |
|--------------------------------|--|---|---|
| AL RECORDS, P.O. BOX 68760 | he law requires that the death certificate be executed within 24 hours after de | e has been signed by the attending physician and completely filled in by the file Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | m 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

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COMPLET

BE

2

96 03876 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH FEBRUARY 2,1996 CORA D. WEBB 4:30 A 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MAY 30, 1924 219-48-4101 1 - M 2 F 71 HOURS MARYLAND YRS. 9s. FACILITY NAME (If not institution, give street end number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH MERIDIAN NURSING HOME DIRECTOR FREDERICK FREDERICK RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY MARYLAND MONTGOMERY GAITHERSBURG 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 7000 WARFIELD ROAD 20882 UNITED STATES 11. MARITAL STATUS t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yee, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced Specify: WHITE COMPLETED 15. DECEDENT'S EDUCATION tea. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only high 16b. KIND OF BUSINESS/INDUSTRY 12 College (1-4 or 5 +) NURSE HOSPITAL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) BASIL DUVALL CATHERINE EVELY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HYTER H. WEBB, HUSBAND 7000 WARFIELD ROAD, GAITHERSBURG, MD. 20882 28a METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE LAYTONSVILLE CEMETERY LAYTONSVILLE, MD. 2/6/96 4 ☐ Donation 5 ☐ Other (Specify) _ 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038 LAYTONSVILLE, MARYLAND 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) neumonic DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a, WAS AN AUTOPSY PERFORMED? blumers d suse 1 TYES 2 NO Directes 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: t YES 2 AG 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4. Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending ВУ

1 YES 2 NO 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined

29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, desth occurred at the time, date and place, and due to the cause(s) and manner as stated, one)

ted.

FRED

| | place and place | e, and due to the couse(s) and manner as stated. |
|---------------------------------------|------------------------------|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER 2 6 7 6 | DATE SIGNED (Month, Day, Year) ► FEBRUARY 2 1996 |

ACCRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Me (IM hos 475

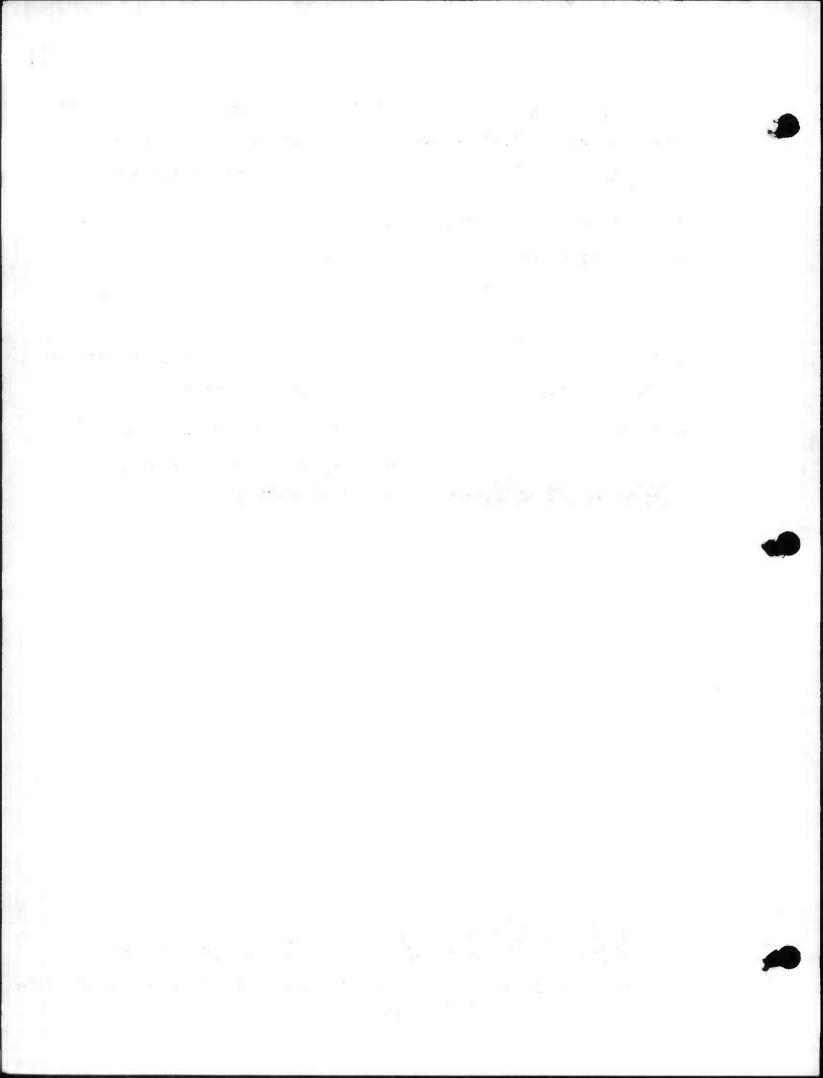
31. DATÉ FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibia

State of Maryland / Department of Health and Mental Hygiene 96 03877

| | | | | | | Cer | tificate | of | Death | | | Reg. No. | | | , , | |
|-----------------|--|----------------|---|--|-------------------|-----------|----------------------|---------------|-----------------------------|-----------------|----------------------------------|-------------------|---------------|--|-----------|--|
| | | | 1. Decedent's Neme (First, Middle, La | ist) | | | - | | | | 2. Deta of Dec | eth | 2765 | 3. Time of | Death | |
| Physic /Medi | | | EVA E. | | | | WILSON | | | | Jan. | 22 | 96 | 3:49 | mg | |
| 1 | Examir | | 4e. Facility Nama (If not institution, give | | | | | 4 | 4b. City, To | wn, or Lo | ocation of Death | 4c. Coun | ty of Death | | | |
| 1 | | | The Memorial | Hospital | at Ea | sto | n | | E | asto | on | 7 | ralbo | t | | |
| | Funeral | | | Sex 7. Ag | a (In yrs. lest b | | If Under 1 Months | Yaar Days | if Undar Hours | 24 Hrs. Min. | 8. Deta of Birt (Month, Da | h y, Year) | 9. Birthp | piace (Stete or | r Foreign | |
| | Director | - | 213-22-7152 | 10 M 201 F | 69 | Yrs. | | | | | OCT. 3 | 1 1926 | MARY | LAND | | |
| | pug *_ | | Usuel Rasidence of Decedent 10e. Stele 10b. County | | 10c. City, Tov | wn or Lo | cation | | | | | | 1 | 0d. Inside Cit | h. Limite | |
| | / sho | ŏ | | | | | | | | | | | | 1 V Yes | | |
| | the the | Director | MARYLAND QUEEN AN 10e. Street and Number | NE | GRASON | A T T T | 10f. Zip C | `ode | | | | 10g. Citizen of | What Cour | ** | | |
| | death with the Maryland irra 23e or 28e-f show if must be notified at | | | DOAD | | | 100 | | _ | | | | WHEI COU | nty r | | |
| | leath ma 23 | era | 1139 PERRY CORNER 11. Merilel Stetus | 12. Wes Decedani | Evar in U.S. | 13. V | | 1638 | | gin? (Sp | ecify Yes or No- | USA 14. Be | ice - Americ | an indian | | |
| 0 | r her | Funeral | 1 Never Merried 2 Married | Armed Forces? 1 ☐ Yas 2 🖔 I | | | | _ | | , Puerto | ecify Yes or No- Rican, atc.) | | ack, Whita, | elc. | | |
| 070 | urs a | by | 3 ☑ Widowed 4 ☐ Divorced If Yes, Give Yeer or Detes: | | | 1 | □ Yes 2 | Ŭ No | Specify: | | | K | | | | |
| 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at ance. | Completed | 15. Decedent's E (Specify only highast gro | ducation | 166 | a. Deced | lent's Usuel | Occup | ation | t of work | ha | 16b. Kind of I | Business/Inc | dustry | | |
| 21 | within ene. then " | npie | (Specify only highast grada completed) (Give kind of work dona during most of work dona during | | | | | | | OF WORK | "iy | | | | | |
| | be filed within ital Hygiene. d other than "evant, the Mex | | 9th | 0 | | DOM | ESTIC_ | | | | | | | SE_HOM | E | |
| anc | od off | Be | 17. Father's Neme (First, Middle, Last | | | | | | | | e (First, Middle, | | me) | | | |
| Ž | should nd Men marks imatic | 10 | CARROLL JOHNS | | | | | | | | RIE FLA | | | | | |
| Maryland | d 2 sh th and 7 is m traum | | 19e. Informant's Neme/Reletionship (| Type, Print) | 19 | b. Mailin | ig Address (| Street | and Numbe | er or Run | al Route Numbe | er, City or Town | n, Steta, Zip | Code) | | |
| | 1 and Health em 27 ther tr | | SAMUEL FLAMER 20a. Method of Disposition | | 20b Place 9 | 182 | WRANGI | ER- | HILL | BEA | R, DELA | WARE, 1 | 9701 | um State | | |
| <u>o</u> | Pages nent of nt: if h | | 1√CkBuriei 2 ☐ Cramation 3 ☐ | | cemate | ary, crem | netory or oth | ar pled | ce) | | Daio | 200. 2002(10)1 | Ony or 10 | , 0.010 | | |
| altimore, | Departme Departme Important any Injury | | 4 ☐ Donation 5 ☐ Other (Special 21. Signeture of Funeral Service Licer | | BRYANS | 5 U. | M. CHU | JRCF | CEMI | E. 1 | /27/96 | GRASON | VILLE | , MD. | | |
| B | Depa Impo any Ir | | 71- 1 | 1 /00 | 12 | RE | ESE & | SON | IS MOI | TILA | RY, PA | | | | | |
| | | Н | 23a. Part1. Entar the diseasa, or com shock, or haert fallure. List only | plications that caused | the deeth. Do | 82 | 1 WEST | ST of dvin | ANI | APO: | LIS, MD | 21401 | | Approximate | | |
| | Physician | | shock, or haert failure. List only | ona ceuse on each lin | ne. | | | | | | ` | | 1 | Interval Betw Onset and D | veen | |
| | Medical | | Immediata Causa (Finel diseese or condition | | Same | | /hlas | 1 | aul4 | 1010 | (A) | | her | 1000 | | |
| | Examiner | | resulting in deeth) | 0. 444 | Dua tolor es e | conseq | uance of): | ici | (NUG U | V (6) | | | 1 | rays | | |
| _ | D = | Examiner | | · Positi | 1. (1) | Mn | 211 | 4 | Vart | 1 10 | D) Yeste | when ! | 1 | dans | | |
| | ertificate be assocuted ling physician and e as the burial-transit | | Sequentially list conditions, if eny, leeding to immediate | b. 105000 | Dua to (or as e | conseq | | _/_' | 1001 | UV | 1 | | | 9 | | |
| 90 | e axe | | reany, leeding to immediate causa. Enter Underlying Causa (Disease or injury that initiated events | | | • | | | days | , | | | | | | |
| 68760 | pt y | edical | thet initiated events resulting in death) Last | 00 | Dua to (or as a | | uenca of): | | | 1 | | | | 10 | | |
| | leath certifica attending pl | 2 | d Jossine and in auced many | | | | | | | | narro | ow Supression aug | | | | |
| 8 | death c e attended for us | ian | | | | 0 | | | | | | 10 | | | | |
| o | 0 8 2 | ysi | Part ii. Other significant conditions of | | | | | isa giv | en in Pert i | | 23b. Dfd t | obacco use c | | | | |
| ٣. | law requires that the death co as been signed by the attend s 2 should be datached for us | by Physician | Afteroscleross Ofomerellunes | s) mec | derat | e | | | | | 10 | Yea 2)K) No | 3 Prol | bably 4 🗆 L | Jnknown | |
| Records, | uires Isign | P | C/ 111. | 1 1 - | , | | • | | | | 24e. Wes | an autopsy | 24b. We | ere autopsy fir | ndings | |
| <u>o</u> | y red shou | lete | U/omeralling | ehritis, | chr | er | nc | | | | perfo | med? | co | eileble prior to mpletion of ca deeth? | iusa | |
| Re | The law ste has page 2 | Completed | | | | | | | | | 1281 | res 2□No | | | Nie | |
| | delan: The | Be Co | 25. Wes case referred to medical | | | | | | 28 Diace | of Deat | h (Check only o | | 1/4 | SYes 2 1 | NO | |
| <u> </u> | | 0 | axaminer? 1 ☐ Yas 2 ☑ No | Hospitel: 1 Inpatia | nl 2 ER/O | utpetient | t 3□ DOA | Oth | or. | | me 5□ Resid | | her (Specifi | v) | | |
| o | | n: T | 27. Menner of Death | 28e. Date of Injur (Month, Day | ry. 28b. | Tima of | | c. Injun | | - | 28d. Dascribe h | | 1.7 | , | | |
| Ö | ath. | atio | 1 Naturel 5 ☐ Pending 2 ☐ Accident investigation | | / roar/ | injury | м | | Yes 2 □ | No | | | | | | |
| | I or Attending Ph after death. Director: After thi I in by the funeral | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | | ury - At home, f | erm, stre | el, fectory, d | office | | | 281. Location (S | Street end Num | ber or Rure | Route Numb | oer, | |
| ۵ | T S S S S S S S S S S S S S S S S S S S | Cer | | | | | | | | | | | | | | |
| | To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the f | edical | (Check only 2 Madical Exam | ysician: To the best of ninar: On the basis of | axamination er | e, deeth | occurred at | tha tim | ne, dete en pinion, deal | d piece, | end due to the d | causa(s) and n | nanner as si | ated. the cause(s) | | |
| | thin 2 the mple | Med | 29b. Signeture and this of confiling | and menner ste | eted. | 90 | 1 = | | e number | 7.11 | | | | | | |
| | 8 4 % 7 | - | MAKUN | 10 | 6/ | ./ | | 12 | aw | 1/ | 200 | 29d. Date/sign | 2 /9/ | egy, redrj | | |
| | | } | 20 Nome and | 1/2/2 | min | 7 | D-last | 2 | 100 | 16 | 134655 | 1/2 | 116 | > " | | |
| | | | 30. Name end addrass of person who | complated cause of de | eetn (Item 23a) | (Type, F | M | D | Lab | , , | MPAGE A | rial. | LASin | tol, E | 石社. | |
| | Sta | te | 31. Date filed (Month, Day, Xear) | 32 Registre | and Signature | 0 | 7 7 10 | 1 | LUCE | , / | , IUVII O | 119/ | 10 / | 104 10 | 10/0 | |
| | Registr | | JAN 29 19 | 96 | Daniel Com | nanca | 14, | | | | | | | - | עויי | |



BALTIMORE, MARYLAND 21215-0020

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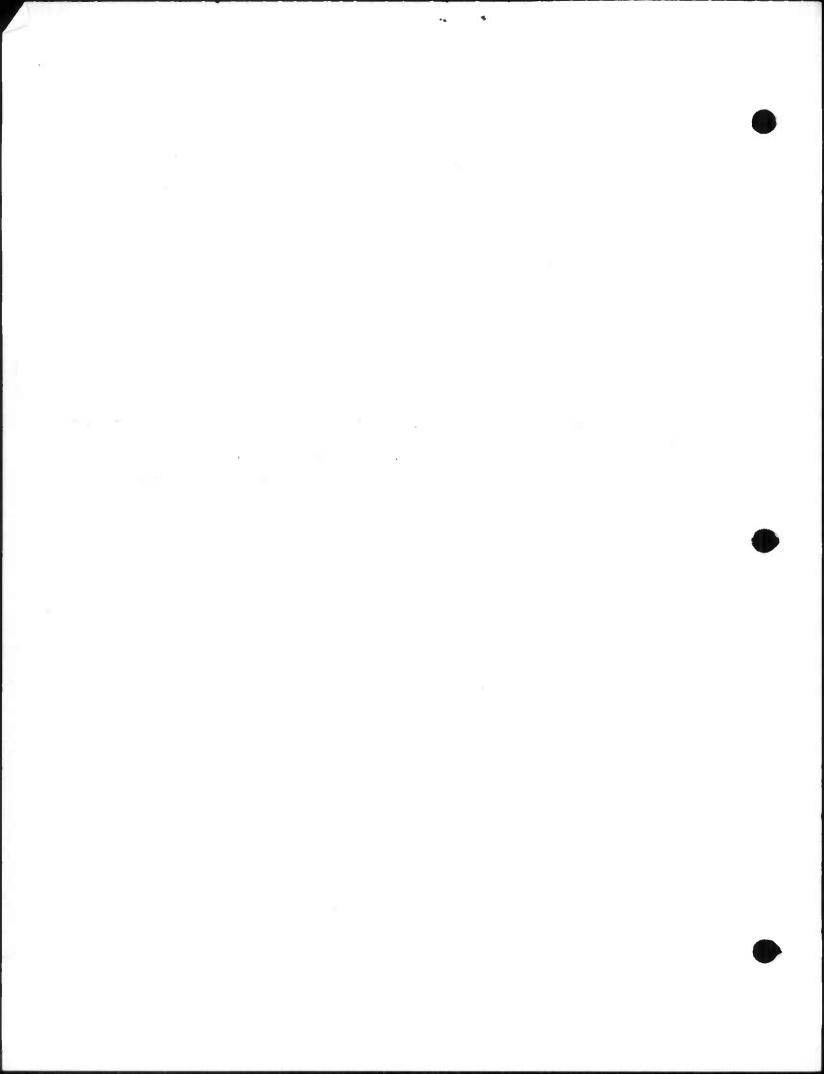
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the forms after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: It liem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H | YGIENE |
|--------------|---|--------|
| REGISTRAR | CERTIFICATE OF DEATH | EG NO |

| | 1 - STATE REGISTRAR | STATE OF N | | | | | DEAT | | MENTAL HY | G. NO. | Ŀ | | | | |
|---------------------|--|----------------------------|---|-----------------|--------------------------------------|------------------|-------------------|-----------|--------------------------------|-----------------------------------|-----------------|----------------|-----------------|--------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | DEA | | 2. DATE OF DE | ATH | | | 3. TIME OF DEA | TH | |
| | | | rd R. Wy | | | | | | Januar | y I | 3, 19 | 968 | 9:00 | ам | |
| | The second secon | 5. SEX | 8. AGE (in yrs. last | | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF BII (Month, Day, | Year) | | Counti | | oreign | |
| _ | 210 - 20 - 1309 | 1 🔀 M 2 🗌 F | 69 | YRS. | | | | | Aug OI | , 19 | 926 | Mai | ryland | | |
| | 9a. FACILITY NAME (If not institution, give street | | | | | | R LOCATIO | ON OF DE | ATH | | | NTY OF D | | | |
| 2 | 5006 Quimby Avenue Beltsville | | | | | | | | | | | Prince George | | | |
| E C | 10e. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CIT | Y | |
| 旹 | Maryland Prince George Beltsville | | | | | | | | | | | | LIMITS? | | |
| AL AL | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN | | | | | | | | | | | IZEN OF V | VHAT COUNTRY? | - | |
| BY FUNERAL DIRECTOR | 5006 Quimby Avenue | 9 | | | | 1 2 | 20705 | , | | | USA | A | | i | |
| 5 | | T EVER IN U.S. ARM | N U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (S If yes, specify Cuban, Maxican, Puarto Rica | | | | | | cify Yes | | 14. RACE | — American Ind | en, | | |
| <u>≻</u> | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE W | MAR OR DATES 1 | | | | 2 XNO | | | etc.) Black, White, etc. Specify: | | | | | |
| | | | 5 - 1947 | | | | | | | | | | White | | |
| IEI | 15. DECEDENT'S EDUCA' (Specify only highest grade co | | (G/ve | e kind of | USUAL Q work done se retired.) | during mos | N st of workin | g | 16b. KIND | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 占 | Elementary/Secondary (0-12) Grade 10 | College (1-4 or 5 + | •} | | | | 20010 | | Cha | _ _ N | la a colo acces | | | | |
| COMPLETED | 17, FATHER'S NAME (First, Middle, Last) | | FLE | CIS. | LOII I | Engir | | ED'C NAA | ME (First, Middle, | | | r THC | lustry | _ | |
| | Wade Medford Wymer | ^ | | | | | | | atherin | | - | .+ | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. | MAILING | ADDRES | S (Street e | | | loute Number, City | | | | - | | |
| 2 | Mary C. Wymer | | | | | | | | | | | | d 20705 | | |
| | 20a. METHOD OF DISPOSITION | | 20h BLACE AN | ID DATE | OE DIEBOI | DITLON (Ma) | | AC / L | | | | City or To | | | |
| | 1 💢 Buriel 2 🗆 Cremation 3 🗀 Ramova 4 🗆 Donation 5 🗀 Other (Specify) | al from State | cemetery, crem | Line | ther place) | Ceme | eterv | 7 | 1/22 | Brer | itwoo | od. M | arvland | | |
| | 4 Donestion 5 Other (Specify) Fort Lincoln Cemetery 1/22 Brentwood, Maryland 21. SIGNATURE OF UNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. | | | | | | | | | | | | | | |
| | ► 1 1/1/4/Cm | () (/) | | | | | | | | | | | 3 0000 | _ | |
| | 23. PART i. Enter the diseases, or cor | mplications that | t caused the dear | th. Do i | not enter | the mod | de of dyl | ng such | Ave. La | urel | etony an | ryla | nd 2070 | | |
| | anock, or Weart Millure. Lis | st only one cau | se on each line. | | | | ac or ayr | | . == 0=101=0 | reapii | atory arr | reat, | Interval B | etween | |
| | iMMEDIATE CAUSE (Final disease or condition paulifing in death) | | | | | | | | | | | | | | |
| | resulting in death) a. Pulmonary Edon Due to (or as a consequence of): Sequentially list conditions. b. Pro-trac main utantion Imanth | | | | | | | | | | | | | | |
| z | - Proton malautoni- | | | | | | | | | | | | | | |
| 일 | It any, leeding to immediate | | | | | | | | | | | | | | |
| 5 | cause. Enter UNDERLYING CAUSE (Disease or injury | A: | OR AS A CONSEQU | S | | | | | | | | | Ima | nth | |
| | that initiated events resulting in death) LAST | DUE TO | | | 00 | | | | | | | | 1 | 11 | |
| CERTIFICATION | d | 180 | | 08 | | | لعال | - | 1 | | | | 1111/6 | DHI | |
| ICAL | PART II. Other significent conditions | contributing to | deeth but not rea | aulting | In the u | nderlylng | ceuse g | iven in F | Part i. 24s. | MAS AN A | WTOPSY | 24b. | WERE AUTOPSY F | | |
| S | Alcoholic | ITHE | e dr | SE | 255 | 2. | | | | YES 2 | | | COMPLETION OF | | |
| MED | | | | | | | | | | | | | 1 YES 2 | NO | |
| ä | DID TOBACCO USE CONTRIL | BUTE TO CA | USE OF DEAT | H YE | S 🗆 | NO 🔽 | UNC | ERTAIN | | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | 28. PLACE | OF DEA | OTHE | | | | | | | | | | |
| PHYSICIAN: | 1 YES 2 NO 1 | | ER/Outpatient 3 | DOA | | | 5 Re | eldence 8 | 8 Other (Spec | ify) | | | | | |
| | 27, MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF (Month, De | | 28b. TIM INJ | E OF URY | 28c. INJU WOI | | | 28d. DESCRIBE | HOW IN | JURY OC | CURED | | | |
| BY | 2 Accident Investigation | | | | М | 1 🗌 Y | | NO | , | | | | | | |
| | 3 Suicide 6 Could not be datermined | building, | F INJURY — At home atc. (Specify) | e, ferm, i | street, fact | lory, office | | | 261. LOCATION City or Town | (Street and, State) | nd Number | or Rural R | loute Number, | | |
| <u> </u> | no- oppring | | | | | | | | | | | | | | |
| I M | 29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. | | | | | | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | | | |
| 6 | 30. NAME AND ADDRESS OF PERSON WHO | P.US | Jayri 1 | M | | | Di | 11; | 560 | | | 11, | 12176 | | |
| | 390 Woutder MANG | NEC L | E PE DEATH (ITEM | 27) (Type, | | -1 - | mo | 2 | 070 | 7 | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. ÆEGISTRAI | R'S SIGNATURE. | 1 -0 | ~~ | | 1110 | | .010 |) (| | | | | |
| | JAN 2 5 1996 | Julia di | R'S SIGNATURE | Call | | | | | | | | | | - 1 | |
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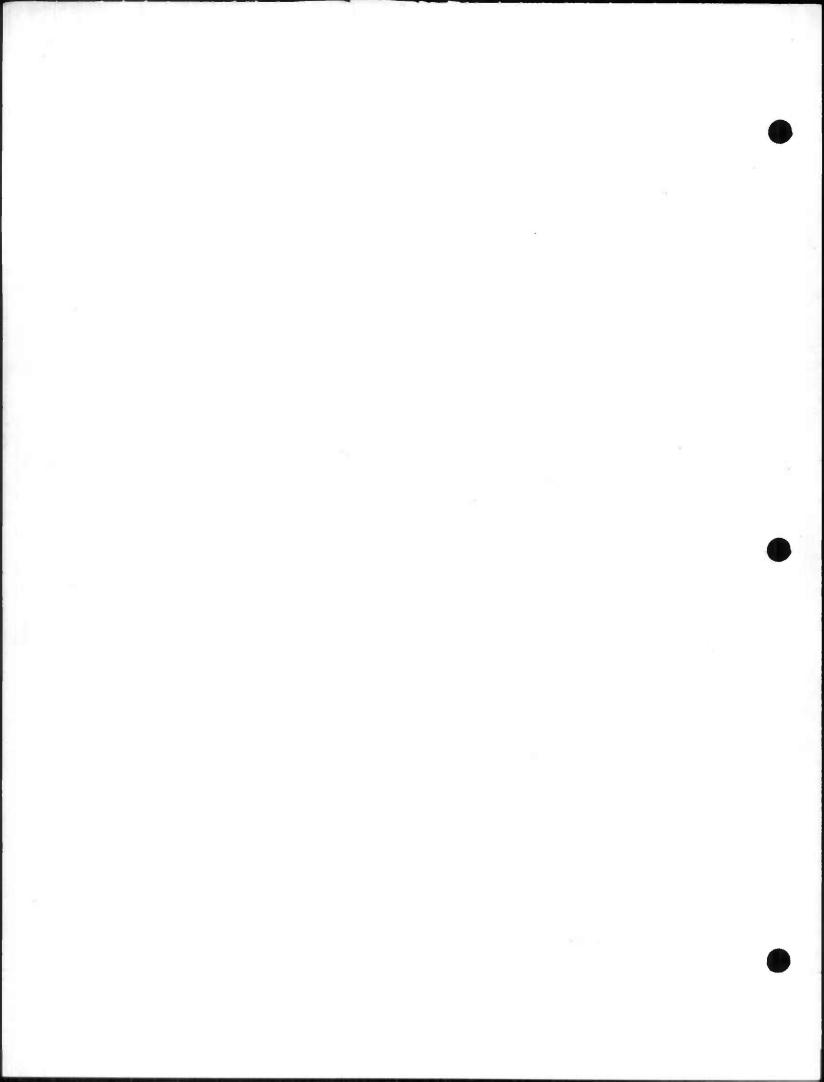
FOR STATE REGISTRAR 1 -TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH WONTH DAY YEAR 3. TIME OF DEATH WONTH DAY YEAR |
|--|---------------|--|
| | | Charles Edward WITT Jan, 30, 1996 11:00 A. " |
| | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) F under 1 YEAR F under 24 Hrs. 7. DATE OF BIRTH (Morith, Day, Year) 7 / C = 2 (-C) / () 1 M M 2 F 5 (YRs. MONTHS DAYS HOURS MIN. / A / / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / |
| Pin | | 16/3 70 1481 - 1 30 - 1 NIAV 12,1727 (VIARVIONA) |
| 3 should | Œ | Residence 12012 Avenue Comberland Allegary Be. COUNTY OF DEATH Residence 12012 Avenue Comberland Allegary |
| 1, 2, | DIRECTOR | RESIDENCE OF DECEDENT |
| Pages | IRE | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? |
| permit. | AL D | Maryland Allegary Cumberland 1 VES 2 IN NO 100. STREET AND NUMBER 100. CITIZEN OF WHAT COUNTRY? |
| | RA | 12012 Mulberry Ave. S.W. 21502 USA |
| 020 physician. burial-transit | FUNER | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No.— 14. RACE — American Indian, Black White electrons and the second of the second or |
| 5-0020 nding physic is the burial | BY F | 1 Never Married 2 Merried 3 Wildowed 4 Divorced FORCES? 1 YES 2 NO If yes, specify Cuben, Mexicen, Puerto Rican, stc.) 1 YES 2 NO Nexicen, Puerto Rican, stc.) 1 YES 2 NO Specify: Specify: White, stc. Specify: No Nexicen N |
| - 65 ra | ED | 15. DECEDENT'S EDUCATION 166. DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTRY |
| 212 | | (Sive kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5 +) |
| 0 5 8 | COMPL | 12 carpenter carpentry |
| the the | 00 | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| RYL ed by | BE | Jamps Arnold witt Delcie Louise Winebrenner |
| MAR retained 5 should notified | 2 | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/502 102 COLUMBIO ST, CUMBENTOWN, State, Zip Code) |
| ay be | | 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION — City or Town, State |
| MOR age 6 ma director, p | | 1 Surtel 2 Cremetion 3 Removal from State Cametary, crematory or other place Cumber (Specify) Cumber (Specify) Cumber (Specify) Property |
| | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY TWC 23 6 Bolt 14000 |
| AL fun fun xan | | rest a. Riley, M. Ave, combenland, Md. 21502 |
| B, nours after of in by the or removal. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. |
| Do Do | | IMMEDIATE CAUSE (Final |
| | | disease or condition resulting in death) s. VENTRICULAR FIRRILLIATION DUE TO (OR AS A CONSCOUENCE OF): 305000005 |
| D 0 1 5 | _ | |
| STOE | CERTIFICATION | Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): |
| | S | cause, Enter UNDERLYING CAUSE (Disease or Injury) |
| o die die | E | that initiated events resulting in death) LAST |
| D # 5 5 | ER | d. |
| The d | | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PROPRIED AMAILABLE PRIOR TO AMAILABLE PRIOR TO |
| that the are any | EDICAL | CHRONIC BETRUCTIVE PULLUCNARY 1 VES 2 DATO COMPLETION OF CAUSE OF DEATH? |
| REC equires en sign of Heal | Σ | 1 YES 2 PNO |
| law law Dept. | AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) |
| DIVISION OF VITAL R OR ATTENDING PHYSICIAN: The law re OIRCOTOR: After this certificate has bee nours after death with the State Dept. c | PHYSICIAN: | EXAMINER? 1 VES 2 NO 1 Inputent 2 ER/Oulpstlent 3 DOA 4 Nursing Name 5 Residence 6 Other (Specify) |
| F V Sician certifi h the S | H | 27. MANNER OF CEATH 280. OATE OF INJURY 286. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED |
| NG PHYS Her this ceath with marked, | ВУ Р | 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation |
| DIVISION OR ATTENDING F DIRECTOR: After t hours after death Item 28 is mar | ED B | 3 Suicide 6 Could not be 26. PLACE OF INJURY — All home, larm, street, fectory, office building, stc. (Specify) (City or Town, State) |
| VISI A ATTEN RECTOR: Urs after m 28 is | | 4 Homicide determined |
| | AP.L | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, end due to the cause(e) end manner ee stated. |
| | COMPL | 2 MEDICAL EXAMINER: On the basic of enumbration end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. |
| THE HOSPI THE FUNER filed within PORTANT: | BE | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) |
| P P 2 M | 0 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED DAUSE OF OEATH (ITEM 27) (Type, Print) |
| 3, 1 | | 296. SIGNATURE AND TITLE OF CERTIFIER 40 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Dev, Weer) 197. 197. 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Dev, Weer) 197. 296. LICENSE NUMBER |
| NS | | 31. DATE FILED (Month, Day, Year) 32. BY STRAB'S SIGNATURE |
| | | 31. DATE FILED (Month, Day, Very) SEB 0.2 1996 32. BESTRAD'S SIGNATURE Satisfaction of the Control of the Co |

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| | | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | PARTMENT TIFICATE | | | MENTAL HYGIEN | | | |
|--|--------------|--|---|---------------------|--|--------------------|-----------------------------|---|-----------------------|-------------------|--|
| _ | | t. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF OEATH | DAY | YEAR | 3. TIME OF DEATH |
| | | | ERLINE | WIT | T | | | | | 996 | 9:29 AM |
| | | 4. SOCIAL SECURITY NUMBER 219-05-4822 | | (In yrs. lest birth | rRS. IF UNDER | | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) Dec 28, | 1918 | 8. BIRTI Count | HPLACE (State or Foreign ry) MD |
| 3 should | ~ | 9a. FACILITY NAME (If not institution, give at | | | | | LOCATION OF DE | ATH | 1 | INTY OF D | |
| 6, | DIRECTOR | MEMORIAL HOSPITAL | & MEDICAL C | ENTER | CUMI | BERLA | WD | | ALL | EGAN | Y |
| iges 1 | EC. | ton. STATE 10b. COUNTY | , | 104 | c. CITY, TOWN O | R LOCATIO | N | | | - | 10d. INSIDE CITY |
| i.j. | | | eral | | Ridgel | | | | | | 1X YES 2 NO |
| -0020 ing physician. the burial-transit permit. Pages 1, | FUNERAL | 10e. STREET AND NUMBER | | | | 7.5 | CIP CODE | | | SA | WHAT COUNTRY? |
| ocian. | NE I | Route 3 Box 414 11. MARITAL STATUS | t2. WAS DECEDENT EVER | IN U.S. ARMED | 13. V | | 26753 IDENT OF HISPAN | HC ORIGIN? (Specify Ye | | 14. RAC | E — American Indian, |
| DD20 | BY FI | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 17 YES | 2 NO | If | f yes, speci | | n, Puarto Rican, etc.) | | Blac Spec | k, White, etc. |
| 8 g 57 | | 15. DECEDENT'S EDUC | WW II | Les proppe | THE HELL OF | 20110171011 | | | | | white |
| or att | COMPLETED | (Specify only highest grade Elementary/Secondary (0-t2) | completed) | (Give Idi | ENT'S USUAL OC nd of work done d NOT use retired.) | during most | of working | 16b. KIND OF BU | JSINESS/IN | DUSTRY | |
| | APLI | 12 | College (1-4 or 5+) | Ret | rired E | ngine | eer | Rail | road | | |
| YLAND 2 by the hospital be detached for | CO | 17. FATHER'S NAME (First, Middle, Last) | | | | | | ME (First, Middle, Maide | | | |
| RYL ed by | BE | Harry Witt | | 1 | | | | i Everlin | | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City or To geley, WV | wn, State, Zi 2675 | | |
| Page bage | | Ruby C. Witt | 20 | b. PLACE AND E | DATE OF DISPOSI | ITION (Name | e of | DATE 20c. L | OCATION - | | own, State |
| TMORE Page 6 may al director, pa | | 20s. METHOD OF DISPOSITION 14. Burlal 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemejary, crematory or other place) Restlawn Memorial Gardens 1/27 LaVale, MD | | | | | | | | | D |
| BALTIMORE, ter death. Page 6 may be the funeral director, page yal. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 11 | 22. | Scarr | ADDRESS OF FA | ineral Hom | e | | |
| | | Clando + | Marpe | elle | | Cumbe | erland, | MD 21502 | | | |
| 24 hours af filled in by on, or rem | | 23. PARTIA. Enter the diseases, or cashock, or has t fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | MYOCARDIAL | oach line. INFAR | RCTION | the mode | of dying, suc | h as Cardiac or rea | piratory si | rrest, | Approximata Interval Between Onset and Death 2 Weeks |
| N 8 5 - 6 | | | DUE TO (OR AS | | | D.F. | | | | | 2 Weeks |
| | NO. | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | 12 WCCKS | | |
| BOX 68 ficate be exect physician and ne prior to but | ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury | RENAL FAIL | | | | | | | _ | 1 Week |
| b. Certifica inding ph Hygiene or other | E | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUEN | ICE OF): | | | | | | |
| | CER | | d | | | | | | | | |
| RECORD: requires that the en signed by the of Health and M thows any Infu | MEDICAL | PART II. Other algorificant condition | | | | | UNCERTAII | PERFO | RMED? | 241 | b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? † YES 2 NO |
| A De De La De De La De L | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | KIBOTE TO CAUSE C | | DEATH (Check of | | OTTERIAL | | | | |
| F VITAL SICIAN: The law certificate has the State Deps. | SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: | ipetiant 3 🗆 0 | OTHER | | 5 🗆 Rasidence | 8 Other (Specify) | | | |
| OF PHYSICI this cer with th | ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 26 | b. TIME OF INJURY | 28c. INJUR WORK | RY AT K? S 2 NO | 28d. OESCRIBE HOW | INJURY O | CORED | |
| ISIC TTENDI TTENDI after di after di 28 is | ED | Accident Investigation 3 Suicide 8 Could not be detarmined 288. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route City or Town, State) | | | | | | | Route Number, | | |
| - 3 3 2 = | COMPLET | one) | CIAN: To the best of my kno | / | | | | | | | |
| HOSPITAL FUNERAL within 72 | 00 | | B: On the basis of examination | on and/or Inves | itigation, in my o | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | how (6) 10 | 2 | | | 29c. LICENSE NUI D 36766 | MBER | | TE SIGNEI | RY 26 1996 |
| 6 | - | 30. NAME AND ADDRESS OF PERSON WH | | | | | | 01500 | | | |
| 112 | | DR. VIK POONAI, 45 31. DATE FILED (Month, Day, Year) | 55 FREDERICK 32. DEGISTRAR'S SIG | NATURE _ | - | AND, | MD | 21502 | | | - |
| | | 31. DATE FILED (Month, Dey, Year) JAN 2, 9 1990 | 5 Jahr dawd | ear Rand | all. | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Lattice State of Maryland / Department of Health and Mental Hygiene 1-29-96 LIASHCU KR Certificate of Death 1. Decedent's Neme (First, Middle, Last) 1717-12-18 2. Dete of Deeth 3. Time of Death **Physician** IK WHITE 0210/th 26 /Medical 4e. Facility Nema (If not Institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Homewood Retirement Center Williamsport Washington If Under 1 Year If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Months Deys 1□M 2FH Yrs. Director 578-54-2209 91 Sept. 25 1904 Maryland Usuei Residenca of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow ahow 1 ☐ Yes 2 ☐ No Director Marvland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health end Mental Hygiene. Important: If item 27 Ia marked other than "natural", or itema 23a or 2 any Injury or other traumatic avant, the Medical Examinar must be n Longmeadow Apartments 21740 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Evar in U,S. Armed Forces? Race - American Indien, Bieck, Whita, atc. 11. Marital Status 1 ☐ Yas 2 🕅 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No à Specify: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Nurse Hospital 17. Fethar's Neme (First, Middla, Last) 18. Mothar's Name (First, Middla, Meiden Sumeme) Be Harry Pryer 2 Mary Elizabeth Ensminger 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Cox (Daughter) 17817 Greentree Lane Hagerstown, Maryland 21740 20b. Pleca of Disposition (Name of cematary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removei from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Greenlawn Memorial Park 1-30-96 Williamsport, Maryland 21. Signeture of Funarai Sarvice Licenses 22. Neme end Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 muck 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each lina. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finai disease or condition resulting in deeth) MOSEPSI Examiner iclan end burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): physiclan es the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 98 USB 0 igned by the at be detached for Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown 9 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed peed hes 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1- Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, and due to the cause(s) and menner as stated.

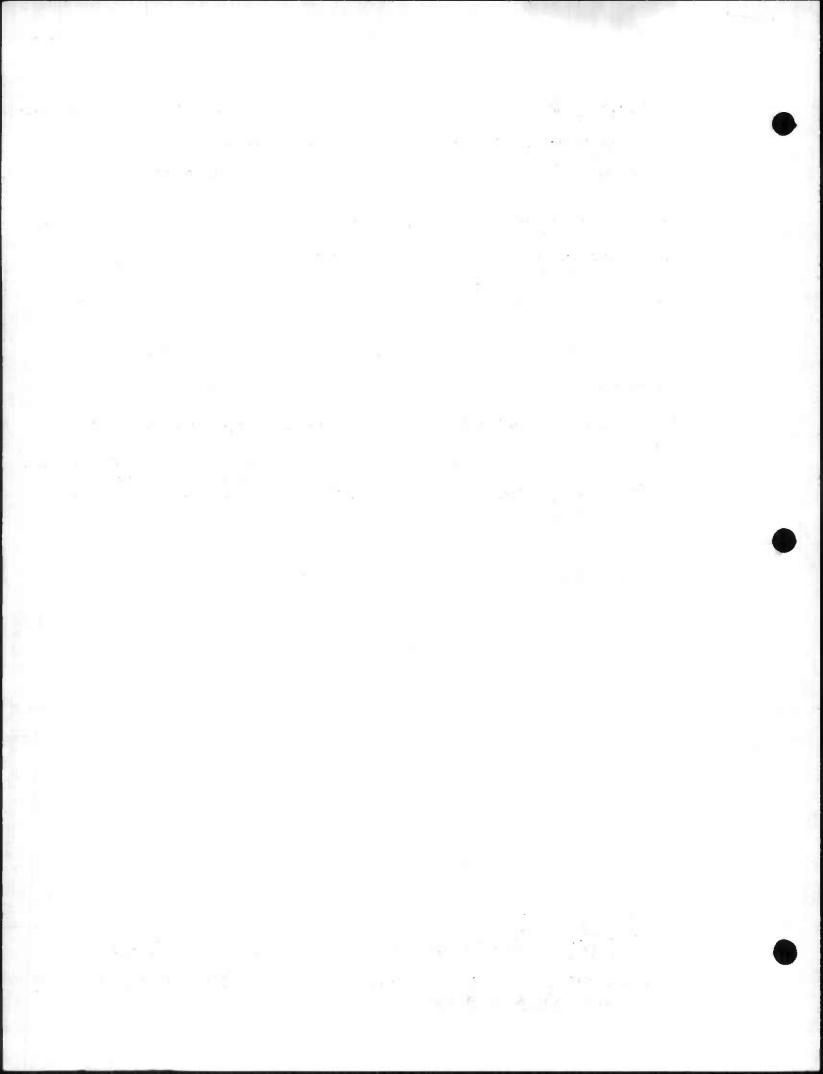
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, daath occurred et the time, date end piece, and due to the cause(s) and menner stated. edical 29e. Certifier 29b. Signetury 29c. Licansa number 29d. Dete signed (Month, Day, Year) 160/CM 1/460 30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)

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State Registrar



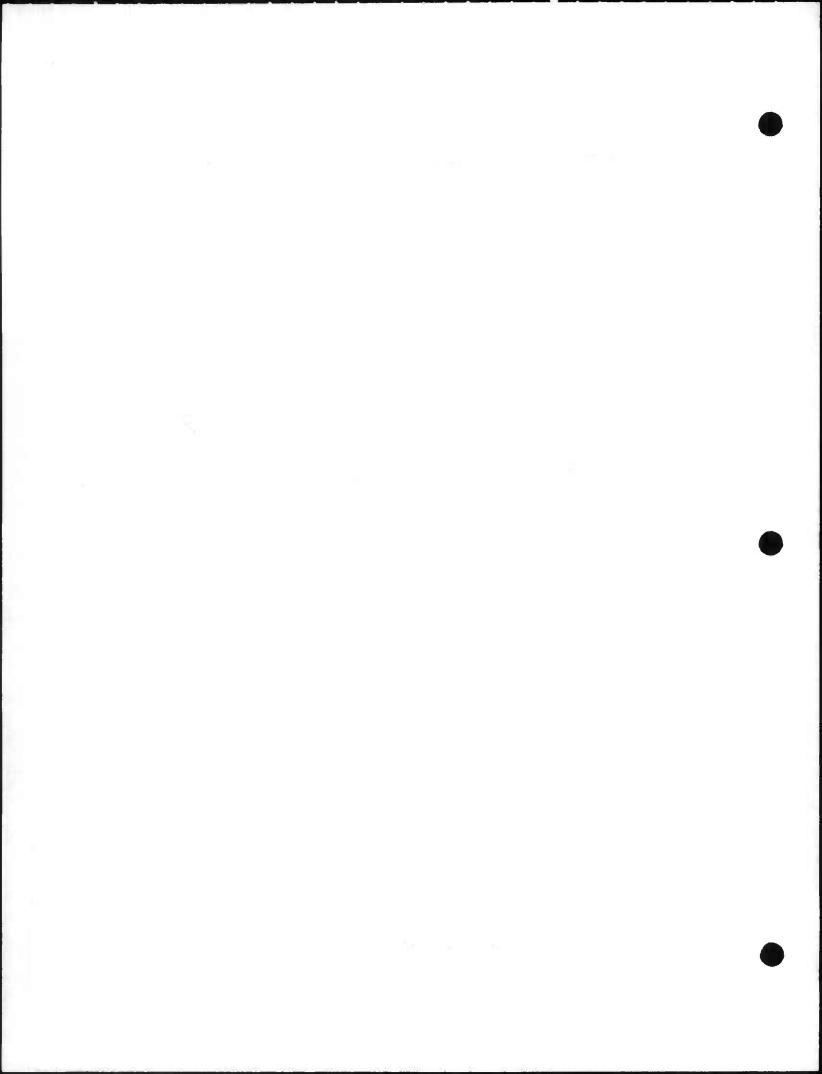
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| | | | | Certificate o | f Death | | g. No. | 112999 | | | | | |
|------------|--|----------------|--|--|---|---|--|--|--|------------|--|----------|--|
| | Physic /Medi | | 1. Decedent's Neme <i>(First, Middl</i> e, <i>Last)</i> Robert Luther WILLMAN | | | 2. Dete of Death Month Jan | 27 199 | 3. Time of Deeth | | | | | |
| | Exami | | 4e. Facility Name (If not institution, give street end number) | | 4b. City, Town, or L Hagerst | ocation of Death | 4c. County of De | ington | | | | | |
| | Funeral Director | | Washington County Hospital 5. Sociel Security Number 214-09-9944 6. Sex 1 M 2□ F 85 | st birthdey) If Under 1 Yes Wonths Dey | er If Under 24 Hrs. | 8. Dete of Birth (Month, Dey,) May 10, | Year) 9. E | Birthplace (State or Foreign Country) aryland | | | | | |
| | land | | Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, 1 | Town or Location | | | | 10d. tnside City Limits | | | | | |
| | e Mary | ctor | Maryland Washington | | | 1 ☐ Yes 2 ② No | | | | | | | |
| | ath with th 23a or 28 | rai Director | 10a. Street and Number 15641 National Pike | 40 | 10 | g. Citizen of What USA | Country? | | | | | | |
| 020 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Mogical Examiner must be normed at | by Funeral | 11. Maritel Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☑ No tt Yes, Give Yeer or Detes: | 13. Wes Decedent of It Yes, specify Ct | f Hispanic Origin? (Spuben, Mexican, Puerto lo <i>Specify:</i> | ecify Yes or No- Rican, etc.) | 14. Rece - Al Bleck, W Specify: W | | | | | | |
| 21215-0020 | in 72 ho | Completed | (Specify only highest grade completed) | 16e. Decedent's Usuel Occ (Give kind of work don life. DO NOT use rati | cupetion ne during most of work ired) | ing | 6b. Kind of Busine | ss/Industry | | | | | |
| 212 | od with giene. | Com | Elementery/Secondery (0-12) College (1-4or 5+) | brakeman | | | railroa | d | | | | | |
| and | d be file antal Hy and oth | Be | 17. Fether's Neme (First, Middle, Last) Luther Robert Willman, Sr. | | | e (First, Middle, Me e Mae Spr | | | | | | | |
| Maryland | 2 should be and Mental is marked or sumatic ever | To | | 19b. Melling Address (Stre | | | | | | | | | |
| | of Health of Health Item 27 | | | | | | | Lillian F. Willman wife 20e. Method of Disposition 20b. Plea | | lonal Pike | | own, Md. | |
| Baltimore, | permit. Pages Department of I Important: If ite any injury or of | , | L Duriel 2 Uremetion 3 Ememover from Stelle | ca of Disposition (Name of natery, cremetory or other page Lawn Mem. I | | | | m, Maryland | | | | | |
| Ball | Depart Import any in | | 21. Signeture of Funerel Servica Licansee | | dress of Fecility FUNERAL HON Lson Blvd. | | www. Md | 21740 | | | | | |
| > | Physician /Medical | | 23e. Pert1. Enter the disease, or complications that caused the deeth. shock, or heert feilure. List only one cause on each line. Immediate Cause (Final disease or condition | Do not enter the mode of d | lying, such es cardiac | or respiretory erres | st, | Approximate Interval Between Onset and Deeth | | | | | |
| | Examiner | | resulting in deeth) e. Due to (or e | s e consequence ot): | | | | Mario | | | | | |
| | outed d ansit | Examiner | Sequentially list conditions b. Due to (or a | utottual se e consequence of): | Bleed | | | 4 augs | | | | | |
| 60, | icate be executed physician and s the burial-fransit | al Exa | If eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury | y to news | <i>-</i> | | | Yeays | | | | | |
| Box 68760, | 들 으로 | in/Medical | thet initiated events resulting in deeth) Lest d. | s a consequence of): | | | | / | | | | | |
| O. B | 0 0 0 | Physician/ | Part II. Other algorificant conditions contributing to death but not resulting | ng in the underlying cause | given in Pert I. | 23b. Did tob | acco use contrib | ute to the ceuee of death? | | | | | |
| S, P. | es that the designed by the a | by Phy | Hour | | | • | | Probably 4 Unknown | | | | | |
| Records | aw requir | Completed b | Athersderatic System Drueutin; Cer | nuc Rea | et deser | 2024a. Wes en performe | autopsy ed? | b. Were autopsy tindings availeble prior to completion of cause of deeth? | | | | | |
| | The ate h | | | Bacuma | ula St. | nde 1□ Yes | 2010 | 1 ☐ Yes 2 ☐ No | | | | | |
| Vital | Physician: The runs certificate real director, pag | o Be | 25. Wes case reterred to me dent examiner? 1 Yes 2 Hospitel: 1 Thinpatient 2 E | R/Outpatient 3 DOA | Where | h (Check only one one 5 Residen | | inecify) | | | | | |
| ion of | After fune | ation: T | 27. Manner of Death 1 Chaturel 5 Pending (Month, Dey Year) 2 Accident 2 Pending (Month, Dey Year) | 8b. Time ot trijury 28c. In | | 28d. Describe hov | | poony | | | | | |
| Division | 5 4 4 5 | Certification: | 3 Suicide 6 Could not be determined 28e. Plece of Injury - At hombuilding, etc. (Specify) | e, term, street, fectory, offic | се | 28t. Location (Stre City or Town, | | Rural Route Number, | | | | | |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical (| 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle condition on the basis of exeminetion one on manner steted. | idge, death occurred et the n end/or investigetion, in m | time, dete end plece, y oplnion, deeth occur | end due to the ceu red et the time, det | use(s) end manner te end piece, end d | es steted. due to the ceuse(s) | | | | | |
| | To the within 2 To the comple | M | 29b. Signeture and title of cartitier AMUSE Chair | 29c. Lice | 36655 | 29 | d. Dete signed (Ma) | onth, Day, Year) | | | | | |
| | | | 30. Neme and address of person who completed cause of deeth (Item 2: | 3e) (Type, Print) | hun m | 10 717 | 140 | | | | | | |
| ľ | Sta Registi | | 31. Dete filed (Month, Dey, Year) 32. Registrer's Signatur | 9 | | | | | | | | | |

Tage 6 may be retained by the hospital or attending physician. director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should E, MARYLAND 21215-0020

| BAL IIMORE, MARYLAND | rs after death. Page 6 may be retained by the hosp | n by the funeral director, page 5 should be detached | edical examiner must be notified at once. |
|---|---|---|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68/60 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and subtained the companies of second of the funeral director, page 5 should be detached to the first companies of second of the funeral director, page 5 should be detached to the first companies of second of the first companies of second of the first companies of second of the first companies of second of the first companies of second of the first companies of second of the first companies of the first | be med writin it indus are used with the 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | DEPARTM | ENT OF HEALTH | AND MENT | TAL HYGIENI REG. NO. | | | | | |
|------------------|--|--|---------------------|---|-------------------|-----------------------------------|--------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Masse, Last) | 7. | | White | MO | NTH DA | | | | | |
| | 1100 | . SEX 6. AGE (in yrs. in | yrs. Mon | THE DAYS HOURS | | TE OF BIRTH | 8. B | IRTHPLACE (State or Foreign ountry) | | | |
| OR | 90. FACILITY NAME (If not institution, give street end number) PENINSULA REGIONAL MEDICAL CENTER 9b. CITY, TOWN OR LOCATION OF DEATH WICOMIC | | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | • , | | WN OR LOCATION | | | | 10d. INSIDE CITY | | | |
| | 10e. STREET AND NUMBER | e last | Fre | Littand 101. ZIP CODE | 0 - / | | 10g. CITIZEN (| 1 TES 2 NO | | | |
| FUNERAL | 311 Morra'S 11. MARITAL STATUS 1 Never Married 2 Merried | 2. WAS DECEDENT EVER IN U.S. A. FORCES? 1 1 YES 2 | RMED | 2 / 13. WAS DECENDENT OF | HISPANIC ORI | GIN? (Specify Yes | Or No. 14. F | SACE — American Indian, Black, White, etc. | | | |
| В | 3 Widowed 4 Divorced 15. DECEDENT'S EDUCAT | IF YES, GIVE WAR OR DATES | | 1 - YES 2 - NO | Specify: | | s | Black | | | |
| COMPLETED | (Specify only highest grade con | npleted) ((| o. Do NOT uso rey | fone during most of working | | (1)11 on | iness/industr | 1 101 | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | white | <u>Cus</u> 10 | | ER'S NAME (FIN | 000000 | Surname) | ilson | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) | te Tr. | 96. MAILING ADD | RESS (Street and Number of | or Aurel Aoyle No | Sonhak | State Zip Code | md. 20174 | | | |
| | 20e. METHOD OF DISPOSITION 1 (8 Suriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify) | 1 from State 20b. PLACE cemetery cr | ANDDATE OF DIS | SPOSITION (Name of lace) | , C 1 | ATE 20c. LOC | ATION - City of | m Jown, State / 2/826 | | | |
| | 21. SIGNATURE OF PURERAL SERVICE LICEN | | | LEWIS | S OF FACILITY | 4750N | FUNE | ERAL HOME and 2/80/ | | | |
| | 23. PART I. Enter the diseases, or com | nplications that coused the d | eath. Do not e | 1618 Wes | | | // | Approximate | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | shock | | | | | | interval Between Onset and Death | | | |
| N | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, b. Withauddominal crisis, not identified | | | | | | | | | | |
| FICATI | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | |
| CERTIFICATION | that initiated eventa resulting in death) LAST | | COURTE OF). | | | | | | | | |
| AL | PART II. Other algorificant conditions of | mart Latine | resulting in th | e underlying ceuse gl | ven in Part i. | 24s. WAS AN A PERFORM | MED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| : ME | DID TOBACCO USE CONTRIB | SUTE TO CAUSE OF DE | ATH YES [| | RTAIN 🗆 | | | 1 WES 2 NO | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLA | CE OF DEATH (C | neck only one) | | | | | | | |
| PHYS | 27. MANNER OF DEATH | Impetient 2 ER/Outpetient : 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | Nursing Home 5 Res 28c, INJURY AT WORK? | | ther (Specify) DESCRIBE HOW IN | JURY OCCURED | , | | | |
| BY | 1 Natural 6 Pending 2 Accident Investigation 3 Suicide 6 Could not be | 28s. PLACE OF INJURY — At he | | M 1 YES 2 | _ | OCATION (Street er | of Alumbar or Burn | and Charles Manager | | | |
| ETED | 4 Homicide 6 Could not be determined | building, etc. (Specify) | | , teatory, office | 201. 60 | ity or Town, State) | o Number or No | TEL PIOUE NUMBER, | | | |
| COMPLETED | | N: To the best of my knowledge, do On the beele of examination end/or | | | | | | se(e) end manner as stated. | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Jenuch n | 10 | 29c. LICEN | ISE NUMBER | 1 | DATE SIGN | NED (Month, Day, Year) V 24, 1996 | | | |
| 5 | 30. NAME AND ADDRESS OF PERION WHO CO | WENRICH | M 27) (Type, Print) | OWER ST. | SA | LISBUR | y m | d. 21801 | | | |
| | JAN 25 1996 | 32. REGISTRAP'S SIGNATURE Jalia d'Avelson A | ardall | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found of the form. Page 6 may be retained by the hospital or attending physician.

TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

6

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | REGISTRAR | | CERTIF | ICAIC | UF | DEAL | п | | REG. NO. | | | |
|---------------|--|--|--|---------------|----------------|----------------------------------|-----------------------|---------------------------------------|------------------------------|-----------------|--|---|
| | DECEDENT'S NAME (First, Middle, Last) GFORGE | onald | WINGROVE | | | | | 2. DATE OF MONTH | DEATH DA | | YEAR 3 | . TIME OF DEATH |
| стоя | 4. SOCIAL SECURITY NUMBER 216–38–9737 | 1 📉 M 2 🗆 F | 6. AGE (In yrs. lest birthday) 83 YRS. | IF UNDER | DAYS | IF UNDER HOURS | 24 HRS. MIN. | 7. DATE OF (Month, I | | | Country) | ACE (State or Foreign |
| | 9a. FACILITY NAME (If not institution, give s 1835 MOUNT HERMON | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | | | | | 9c. COUNTY OF DEATH WICOMICO | | | |
| K | RESIDENCE OF DECEDENT | NOAD | | DAL. | LDDC | IXI | | | | MICC | MILCO | |
| DIRECTOR | Maryland Wic | 10c. CIT | Y, TOWN O | r LOCAT | | | | | | | Od. INSIDE CITY LIMITS? VES 23 NO | |
| | 10s. STREET AND NUMBER | | | | _ | . ZIP CODE | | | | 10a. CITIZ | | AT COUNTRY? |
| FUNERAL | 1835 Mt. Hermon | | | | | 218 | 01 | | | | USA | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | | EVER IN U.S. ARMED YES 2 NO AR OR DATES | 16 | yes, sp | ENDENT O ecity Cuba 2 X NO | n, Mexica | NIC ORIGIN? (in, Puerte Ric y: | Specify Yes an, stc.) | or No— | Soecity: | - American Indien, White, etc. |
| 9 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S (Give kind of | work done d | CUPATIO | ON st of workin | a | 16b. K | IND OF BUS | INESS/INDL | JSTRY | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Ille Da NOT II | se retired.) | | | | C | hemis | trv | | |
| O | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTH | IER'S NA | ME (First, Mid | | | _ | |
| BE C | George | Wingrov | e | | | | Ammy | | | Fish | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | 20.5 | | ADDRESS | (Street a | nd Number | or Rural I | Route Number, | City or Town | n, State, Zip (| Code) | |
| F | Gay K. Wingrove | | 1835 | Mt. | Her | mon l | Rd., | Sali | sbury | ,MD 2 | 1801 | |
| | 20e. METHOD OF DISPOSITION 1 | ovel from State | 206. PLACE AND DATE cometery, crematory or constant Salisbur | of Disposi | TION (No | me of | | DATE | 20c. LOC | alisb | | |
| | 21. SIGNATUME OF MUNERAL SERVICE LIC | ENSEE | Joanisbui | 22. P | NAME A | ID ADDRES | S OF FA | neral | | alisu | ury,r | ·ID |
| | Nound of | . (Rome | m | | | | | | | Lisbu | rv.MI | 21801 |
| 7 | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Due To (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | c | OR AS A CONSEQUENCE O | | | | | | | - | | |
| | PART II. Other algnificant condition | a contributing to | death but not resulting | In the un | derlyIn | g cause g | lven in | Part I. 2 | 4a. WAS AN | | | ERE AUTOPSY FINDINGS |
| EDICAL | CARCINOMA PROST | ATE | | | | | | | PERFOR | | 0 | MAILABLE PRIOR TO OMPLETION OF CAUSE |
| 2 | CHRONIC OBSTRUC | TIVE PULN | MONARY DISEA | ASE | | | | | | (M) | | F DEATH? |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 26 Dr | ACE OF O | EATH (C) | eck only one) | | | | |
| 200 | EXAMINER? 1 X YES 2 NO | HOSPITAL: | ER/Outpatient 3 □ DOA | OTHER | l: | | | 6 Other | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF I (Month, Date of 1) | INJURY 28b. TIR y, Year) IN | IE OF JURY | 28c, INJ WC | | | 28d. DESC | TNFL | | URED | |
| ED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | INJURY — At home, farm, etc. (Specify) | street, facto | ory, offic | | , 40 | 261. LOCAT City or | ION (Street a Town, State) | and Number of | or Aural Aou | ite Number, | |
| Fi | 29a. CERTIFIER | | DUNT HERMON | _ | | | | | BURY | | _ | |
| COMPLETED | (Check only 1 CERTIFYING PHYSI | | my knowledge, death occurrentiation and/or investigation | | | | | | | | | nd menner as stated. |
| BE | SIGNATURE AND TITLE OF CERTIFIES | ledle | m. M.D. | D.M. | E - | 29c. LICE DO35 | NSE NUI | MBER | | | ************************************** | forth, Day, Year) |
| 2 | JOHN T. BULKELEY | | E OF DEATH (ITEM 27) (Type | , Print) | | | | RY, MI | 2180 | | | |
| | JAN 24 1996 | 32_REGISTRAF | r's SIGNATURE | | | | | | | | | |

water and the sales of the sale

BALTIMORE, MARYLAND 21215-0020

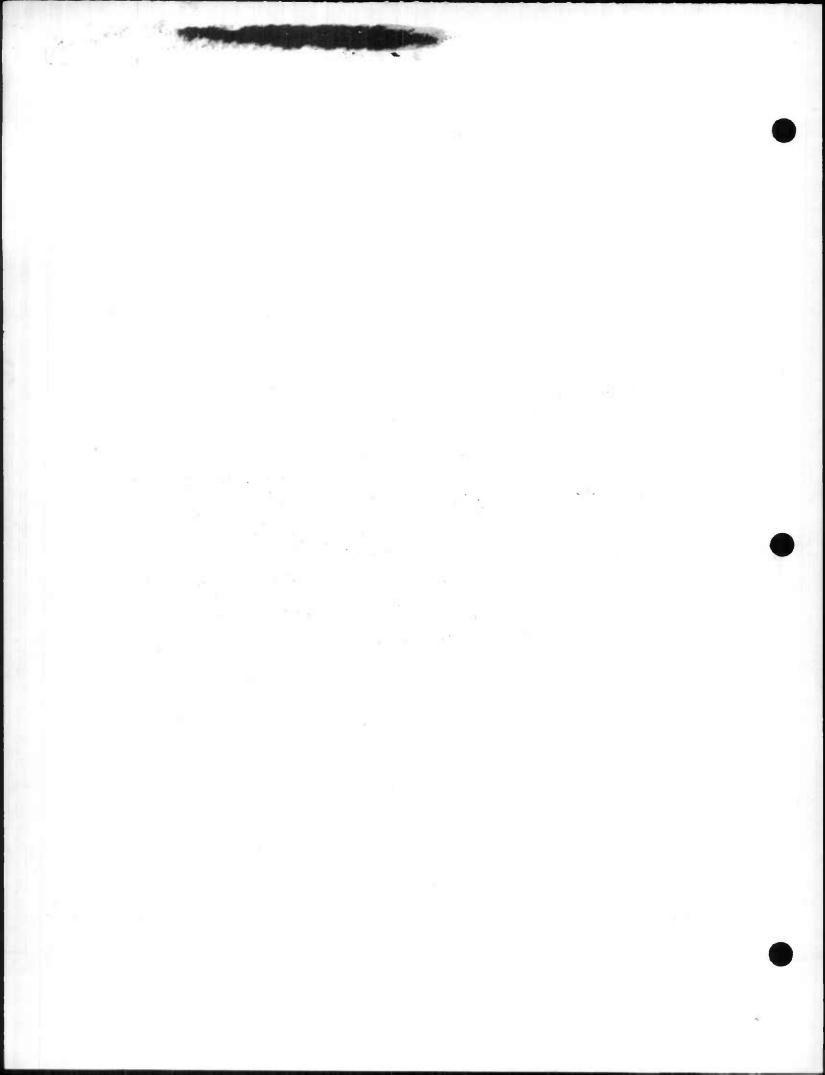
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| REGISTRAR | | CERTIF | ICAIE | PUEAIR | RE | G. NO. | | | |
|---|--|----------------------------|-------------------|--|--------------------------------|--------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DE | DAY | 3. TIME OF DEATH | | |
| Madely | yn M. | Ward | | | Janua | ry 26, | 1996 11:00 p™ | | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | GE (In yrs. last birthday) | IF UNDER 1 YEAR | | 7. DATE OF BIF (Month, Day. | RTH | 8. BIRTHPLACE (State or Foreign Country) | | |
| 217-10-2200 | 1 M 2 K F | 95 YRS. | MONTHS DAYS | HOURS MIN. | June | 18,190 | 0 Virginia | | |
| 9a. FACILITY NAME (If not Institution, give | street and number) | | 9b. CITY, TOW | N OR LOCATION OF D | | | INTY OF DEATH | | |
| 19 Franklin St | treet | | Ahe | rdeen | | 3 119 | Harford | | |
| RESIDENCE OF DECEDENT | CICCC | | 1100 | racen | | | 1011010 | | |
| 19 Franklin St RESIDENCE OF DECEDENT 108. STATE 108. COUNT | TY | 10c. CIT | Y, TOWN OR LO | CATION | | | 10d. INSIDE CITY LIMITS? | | |
| | Cecil | E | lkton | | | | 1 X YES 2 NO | | |
| 10e. STREET AND NUMBER | | | | 10f, ZIP CODE | - | 10g. CIT | IZEN OF WHAT COUNTRY? | | |
| 104 Washington | Avenue | | | 21921 | | U. | S.A. | | |
| 104 Washington 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVE | | | ECENDENT OF HISPA | | cify Yes or No- | 14. RACE — American Indian, Black, White, atc. | | |
| | FORCES? 1 Y | | | specify Cuban, Maxic ES 25 NO Speci | | atc.) | Specify: | | |
| 3 Widowed 4 Divorced | | | | | , | | White | | |
| 15. DECEOENT'S ED (Specify only highest grac Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) | | 18a. OECEDENT'S | USUAL OCCUPA | TION | 16b. KIND | OF BUSINESS/IN | OUSTRY | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | se retired.) | most of working | | | | | |
| 12 | 3 | Home | emaker | | IN | N Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N. | AME (First, Middle, | Maiden Surname) | West of the last o | | |
| | beim | | | Eliza | beth Wa | tson | | | |
| 10. INFORMANT'S NAME /Sma/Brist | | 19b, MAILING | ADDRESS (Street | et and Number or Rural | | | ip Code) | | |
| Mrs. Patricia Ta | nner | | | Street, | | | | | |
| 20a. METHOD OF DISPOSITION | I | 20b. PLACE AND DATE | | | - | | - City or Town, Stata | | |
| 1 Burial 2 Cremation 3 Read A Donation 5 Other (Specify) | moval from State | Spesutia (| | | 1/29 | | n, Maryland | | |
| 21. SIGNATURE OF FUNCTIAL SERVICE L | ICENSEE | spesucia (| | AND ADDRESS OF F | | retryma | ii, Maryiana | | |
| | 0 () | | Tarr | ing-Cargo | Funera | al Home, | P.A. | | |
| Emmetty ! | B. Gara | 0, | | deen, Mary | | 21001-33 | 99 | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO IOM AS A CONSEQUENCE OF) | | | | | | | | |
| | ons contributing to dea | th but not resulting | In the underly | dog cause given i | n Part i 24a | WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | |
| | | | | | 1 | PERFORMED? | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL | 1 | 26. PLACE OF DEA | | | | | | | |
| EXAMINER? | HOSPITAL: | (Outpatient 3 DOA | OTHER: | forme 5 Raeldence | 8 17 Other (See | no/fiel | | | |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | 28a. DATE OF INJU | | | INJURY AT | | E HOW INJURY O | CCURED | | |
| | (Month, Day, Ye | ear) IN | JURY | WORK? YES 2 NO | | | | | |
| 2 Accident Investigation | | JURY — At home, farm, | | | 281 LOCATION | I (Street and Numb | er or Rural Route Number, | | |
| 3 Suicide 8 Could not b 4 Homicide determined | building, atc. | (Specify) | ander, ractory, c | 771100 | City or Tox | vn, State) | or or theret there exercises, | | |
| III III III III III III III III III II | | | | | | | | | |
| Cornect orny | SICIAN: To the best of my NER: On the bests of axami | | | | | | ated. The cause(a) and menner as atated. | | |
| | IER C | 1- | | 29c, LICENSE N | UMBER | 29d. D/ | TE SIGNED (Month, Day, Year) | | |
| 181 | T Cham | WD | | DIE | 142 | > | 12976 | | |
| 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CALLER O | F DEATH (ITEM 27) /5m | a Print) | 110,0 | 10 | | 1-1110 | | |
| B. TV | 1 / 1 | 0.4 | 1 0 | 11Ninal | AV | 110,000 | deGrACEMO. | | |
| | EO MD. | SIGNATURE | ' ', | CATT ON | 77. | THITE | de (Track MD. | | |
| 31. DATE FILED (MATTIL DOUDS OF 190 | 6 Julia Day | SIGNATURE RAVIALL | | | | | | | |



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| HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | IF FUNERAL ORRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | PORTANT: II Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|--|
| TO THE HOSPITA | TO THE FUNERAL | be filed within 72 | IMPORTANT: II |

96 03886 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR CARL WATERS ROBERT January 10:10 AM M 1996 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreig IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH New York Aug. 21, DAYS HOURS MONTHS 087-20-7629 1 XM 2 F 66 YRS. 1929 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Towne Center Drive Joppatowne Harford RESIDENCE 10b. COUNTY 10a, STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Joppatowne 1 YES 2 XNO 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 642 Towne Center Drive 21085 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian Black, White, etc. 1 Never Married 2 X Married Specify: white IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced 1951 - 1954 COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Superintendant Printing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname Lavon --- Dix Harold --- Waters BE 19a. INFORMANT'S NAME (Type/Print)
Ruth A. Waters 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 642 Towne Center Drive, Joppatowne, Maryland 21085 20a. METHOD OF DISPOSITION
1 [XBuriel 2 | Cremetion 3] 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Vestal Hills Memorial Park 2/2/96 Vestal, New York 4 Donation 5 Other (Speci PUNERAL BE 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdisc or respiratory errest, Approximeta ehock, or heart fellure. Liet only one cause on each line. interval Between Onset and Deeth IMMEDIATE CAUSE (Final DUE TO (OR AS A CONSEQUENCE OF): disease or condition resulting in death) month DUE TO (OR AS A CONSEQUENCE OF): RUR CERTIFICATION Sequentially ilst conditions, If eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART il. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 TYES 2 NO 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO W UNCERTAIN I PHYSICIAN: 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 -DOA 4 Nursing Home 5 Residence 6 Other (Specify)

28b. TIME OF INJURY 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident 5 Pending Investigation 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be

29a. CERTIFIER
//Check only

1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as ateted.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) (mle) an

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

determined

FEB 1

Backme TCHNS Itophers Huspill 31. DATE FILED (Month, Day, Year)

32. APPENTANTS, SIGNATURE PANDALL 1996

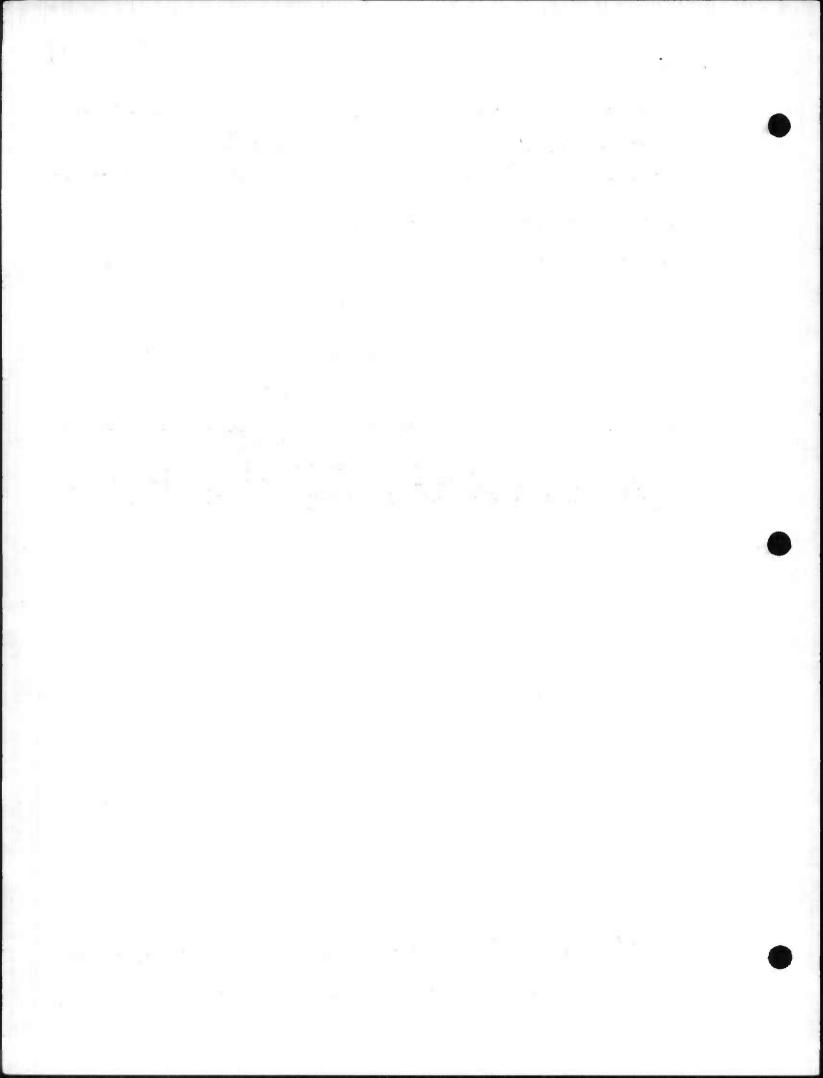
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State of Maryland / Department of Health and Mental Hygiene

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| | | 4 | | | | Ce | rtificat | e of | Death | | 1 | Reg. No. | 20 | 00001 | |
|------------|---|----------------|--|------------------------------|---------------------------------------|----------------------------------|--------------|--------------------|-------------------|---------------|--|--------------------------|------------------|--|--|
| | | | 1. Decedent's Neme (First, Middle, La | ıst) | | | | | | | 2. Dete of Dee | eth | | 3. Time of Death | |
| | Physician /Medical | | Roela | Web | er | | | | | | Month January | Day 25 | Yeer 1996 | 9:30 AM | |
| | /Medi Examii | | 4e. Fecility Neme (If not Institution, give | | | | | | 4b. City, To | wn, or Lo | cation of Deeth | | County of Dee | | |
| | LAGIIII | iei | Meridian Nursing | Пото | | | | | Cilve | | | M | (ont con | 20.844 | |
| - | Funeral | | | Sex | 7. Age (In yrs | lest birthday) | If Under | 1 Yeer | Silve If Under | 24 Hrs. | | | ontgon | rthplace (State or Foreign | |
| | Director | п | | 1□ M 2♥ F 73 | | Yrs. | Months | Deys | s Hours Min. | | 8. Dete of Birt (Month, De) July 6 | | C | ountry) | |
| | | | Usuel Residence of Decedent | | / 3 | | | | | | Duly o | 192 | z Net | herlands | |
| | dano | | 10e. Stete 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | | | 10d. inside City Limits | |
| | Many | ō | Maryland Montgo | mart | | Silver | Corr | na | | 1 ☐ Yes 2X No | | | | | |
| | 150 280 280 | Director | 10e. Street end Number | шету | | STIVEL | 101. Zic | _ | | | 10g. Citizen of What Cor | | | ountry? | |
| | with | | | | | | | | | | Tog. Chizert of What Country? | | | oditiy r | |
| | eath m 23 | era | 14508 Homecrest I | | Oad 12. Wes Decedent Ever in U,S | | | 2090 | | ain? (Ca | noite Van az Na | | ted St | | |
| - | iten d | Funeral | 1 Never Merried 2 Married | Armed Forces? 1 ☐ Yes 2 🛣 No | | 7,0. | If Yes, spe | cify Cub | en, Mexicar | , Puerto | ecify Yes or No- Rican, etc.) | , | Bleck, Whi | | |
| 21215-0020 | rs ar | by F | 3 Widowed 4 Divorced | If Yes, Gi | ve | | 1 🗆 Yes | 2 🖾 No | Specify: | | | 5 | Specify: | | |
| Ş | hin 72 hours after death with the Maryland p. in "naturel", or flems 23a or 28a-f show Medical Examinet must be notified at | | 15. Decedent's E | | | 16a. Dece | dont's Heu | ni Onnu | nation | | | 10h Min | | hite | |
| 5 | n 72 | Completed | (Specify only highest gra | ade completed) | | (Give | kind of wo | rk done | during mos d) | t of work | ing | 100. Kind | d of Business | vindustry | |
| 12 | 7 2 4 | m | Elementery/Secondery (0-12) | Coilege (| 1-4or 5+) | | Desi | | • | | | ٠. | Clathi | | |
| 0 | e filed with Il Hygiene. other than | | 17. Fether's Neme (First, Middle, Last | 4 | | | Desi | gner | | r'e Nome | e (First, Middle, | | Clothi | ng | |
| an | 0 = 0 5 | Be | | | | | | | 100 | | | | | | |
| Z | 2 should be f and Mental H ie marked of raumatic eve | 10 | Harm Oving | | | | | | | | hien Br | | | | |
| Maryland | 12 sl 12 sl 10 m | | 19e. informant's Neme/Reletionship (| Type, Print) | | | | | | | al Route Numbe | | | | |
| | s 1 and 2 // Health a item 27 le other trai | | George A. Weber | | 001 | 3040 | Duba | rry | Lane, | Bro | okevill | | | | |
| 0 | r of F | | 20e. Method of Disposition 1 ☐ Burial 2 🖾 Cremetion 3 ☐ | Removei from | State 200. | Piece of Dispo cemetery, cres | netory or c | ne or other ple | Janu | ary , 19 | Date 196 | 20c. Loc | eation - City or | Town, State | |
| altimore, | Pa men ant: ury | | 4 ☐ Donetion 5 ☐ Other (Special | | | ntgome | | | | 7 - | ic. | Bethe | esda, 1 | Maryland | |
| a | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enosities. | | 21. Signeture of Funerel Service Lice | 10 | - 21 | 0831 22 | 2. Name er | d Addre | ess of Fecili | y Rob | ert A. | Pump | hrey F | uneral Home/ | |
| 0 | 80 = 8 8 | | Darbara 40 Mol | nolley | Town | ce Be | ethes | da-(| Chevy | Chas | e, Inc. | 75 | 57 Wis 814-35 | consin | |
| | _ | | 23a. Part1. Enter the disease, or com- shock, or heart feilure. List only | plications that o | aused the dee | | | | | | | | 014-22 | Approximate | |
| ĸ. | Physician | | Onset end De | | | | | | | | | | | Intervel Between Onset end Deeth | |
| | /Medical | ш | tmmediate Cause (Final | 24. 1 | | 5 | | | | | | | | i | |
| | Examiner | ш | disease or condition resulting in deeth) | e. Met | castati | c Breas | | | oma | | | | | 2 years | |
| | | je | | | | | | | | | | | | | |
| | sath certificate be executed attending physician and for use as the burial-transit | Examiner | Convention to the secondary | bMu. | | Patholo or es e consec | | | ractur | es - | pelvis | | | 1 | |
| Ć, | exec n an ial-tr | Exa | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying | | | | | | | | | | | | |
| 92 | certificate be executed nding physician and use as the burial-transit | Cal | cause. Enter Underlying Ceuse (Diseese or injury that initieted events | | r es e consequence of): | | | | | | | 1 | | | |
| 68760, | ficat phy s th | Medical | resulting in deeth) Last | | | | | | | | | | | | |
| × | centi nding | 3 | | d | | | | | | | | | | | |
| 80 | atte | cla | | | | | | | | | | | | | |
| o | the death y the atter sched for t | Physician/ | Pert ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. | | | | | | | | | e to the cause of death? | | | |
| 0 | that ed b | | | | | | | | | | 101 | res 2X2 | INo 3□P | robably 4 Unknown | |
| d's | 8 5 8 | d by | | | | | | | | | 040 14400 | | 246 | Were autopsy findings | |
| Ö | | ete | | | | | | | | | 24e. Wes | med? | 1 | aveilable prior to completion of cause | |
| Records, | \$ 5 W | Completed | | | | | | | | | | | | of death? | |
| | Pa ate | Co | | | | | | | | | 1 D Y | es 2 | No | 1 ☐ Yes 2 ☐ No | |
| Viita | Physician: The this certificate ral director, pag | Be | 25. Wes case referred to medical examiner? | | | | | | 28. Place | of Deet | (Check only o | ne) | | | |
| o | Physic this c | 2 | 1 ☐ Yes 2 No | Hospitel: 1 | inpatient 2 | ER/Outpetier | nt 3□ DC | DA Ot | her: 4 🖾 Nu | rsing Ho | me 5 Resid | lence 8 | □Other (Spe | ecify) | |
| | | :io | 27. Menner of Deeth 1 Neturei 5 ☐ Pending | 28e. Dete (Mon | of Injury th, Dey Year) | 28b. Time of injury | 2 | 8c. Inju Wo | ry et rk? | | 28d. Describe h | ow injury | occurred | | |
| Division | Attending Industry death. | ati | 2 ☐ Accident investigation | n | | | М | | Yes 2□ | No | | | | | |
| > | or Attendation of Director: | tific | 3 Suicide 6 Could not b 4 Homicide determined | 289. Piece | of injury - At h | ome, ferm, str | eet, factory | , office | | | 28f. Location (S City or Tow | | Number or R | tural Route Number, | |
| ā | tal or A | Certification: | | | · · · · · · · · · · · · · · · · · · · | ,,, | | | | | | .,, | | | |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by | | 29e. Certifier 1 Certifying Ph | ysician: To the | best of my kno | wledge, deeth | occurred | et the ti | me, dete en | d piece, | end due to the | ause(s) e | nd manner a | s stated. | |
| | he H in 24 he Fi | edical | (Check only one) 2 Medical Exam | and men | asis of exemine ner steted. | mon end/or in | restigetion | , in my o | pinion, dee | tn occurr | ed at the time, o | sete end p | ece, end du | e to the ceuse(s) | |
| | With To the | Σ | 29b. Signeture and title of cartifier | | , | 0 | 290 | . Licens | se number | | | 29d. Dete | signed (Mon | th, Day, Year) | |
| | | | Wilhuns | ~ J. | Niv | iala | | D | 5285 | | | Tanin | anuary 26, 1996 | | |
| | | | 30. Neme and eddress of person who | completed caus | e of deeth /iter | m 23e) (Type | Print) | D4 | 3203 | | | Janu | ary 20 | , 1330 | |
| | | | Wilkinson Ninala, | | | | | in r |)riv- | #21 | 2 01 | 2.0 | D 200 | 2.2 | |
| | Sta | te | 31 Date filed (Month Day Year) | 32 B | Agistrary Block | ture P. | LILL. | TD T | TIVE, | #41 | Z, UINE | A ' M | 208 | 26 | |
| | Registr | | JAN 31 1 | 996 | he grand | MAN INDIVIDU | D.A. | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 96 Amended #1, 1/30/96, MRT, Montg. Cty. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Carroll F. Warner Month Carroll Warner 27,1996 5:00 am January 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fairhaven Retirement Center Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 6. Sex 1Å M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Yrs. 577-03-6540 84 Sept. 4,1911 Mary land Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue, C-086 21784 United States Raca - American indian, Biack, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coliege (1-4or 5+) Division Manager Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) H. Ernest Warner Ella Fisher 19a. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn O. Warner 7200 Third Ave., C-086, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, cremetory or other place)

January 30,1996 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Ave., Rockville, Maryland 20850-2805 M00348 23a. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in deeth) cancer of the puncreas 16 mos Due to (or es a consequence of) Sequentially ilst conditions, if any, leeding to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Due to (or es a consequence of):

Physician /Medical **Examiner**

ettending physician and for use as the burial-transit

The lew requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

n/Medical Examiner

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Nem 27 is marked other any Injury or other traumatic event

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Modical Experience must be incuried as

filed within 72 hours efter deeth Hygiene.

Baltimore, Maryland 21215-0020

the Maryland

29b. Signature end title of certifier

| Part II. Other algorificant conditions of | ontributing to death but not re- | sulting in the underlyin | g cause given in Part I. | 23b. Did tobacco use co | ontribute to the cause of death? 3 Probably 4 Unknown | | |
|--|---|--|--|---|---|--|--|
| | | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings aveileble prior to completion of cause of death? | | |
| 25. Was case referred to medical | | eeth (Check only one) | (Check only one) | | | | |
| examiner? 1 ☐ Yes 2 🛣 No | Hospital: 1 ☐ inpatient 2 ☐ | ☐ ER/Outpatient 3☐ | | me 5 ☐ Residence 8 ☐ Other (Specify) | | | |
| 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation | | 28b. Time of injury | 28c. injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred | | | |
| 3 ☐ Suicide 8 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At h building, etc. (Special | nome, farm, street, fact | 28f. Location (Street and Numb City or Town, State) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 Certifying Phy | valcian: To the best of my knotiner: On the basis of examination and menner steted. | ce, and due to the cause(s) and mocured et the time, date and plece, | anner as stated. and due to the cause(s) | | | | |

29c. License number

034406

1645 Liberty Rd., Eldersburg, MD 21784

29d. Dete signed (Month, Day, Year)

27/96

Richmond P. Allan. 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature Julia Davidson Rardall JAN 30 1996

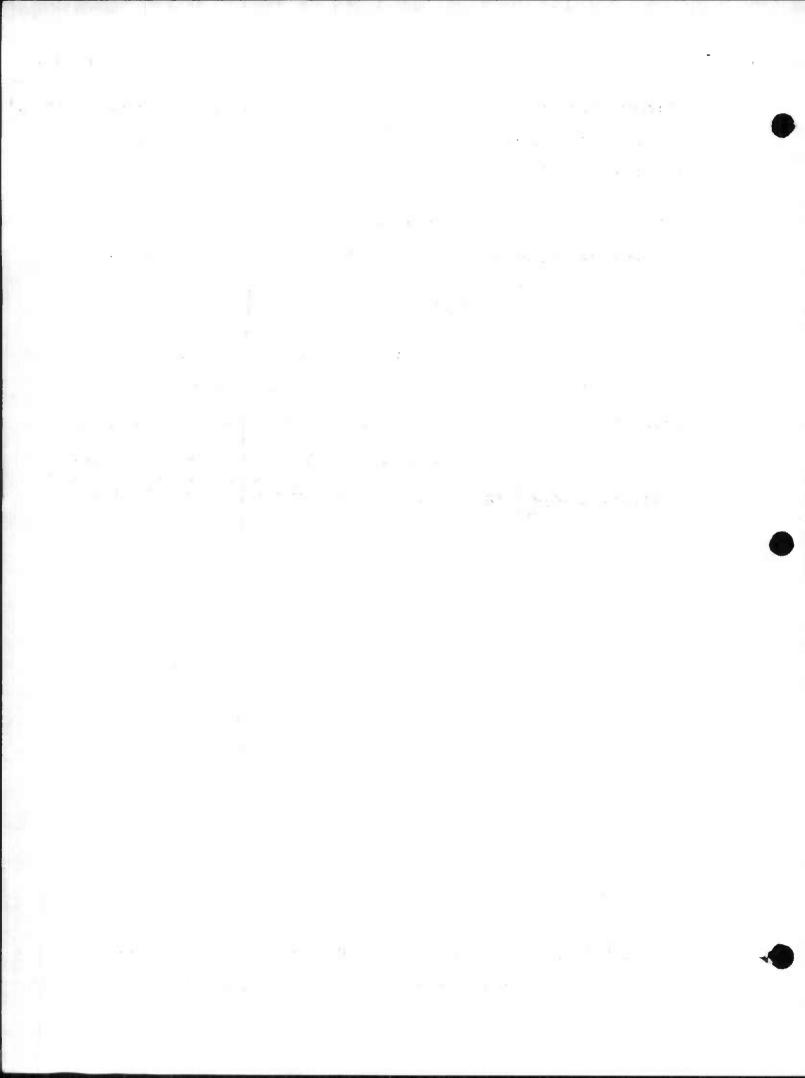
n C. UN MO

30. Neme and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 16 Ray 6/95

To the Hospital or Attending Physician: Within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director; I



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any finjury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI CERTIFIC | | | | GIENE B. NO. | | | | |
|----------------------------------|--|--|--|-----------------------------------|--|---|--|------------------|---------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | (1) | | 2. DATE OF DEATH 3. TIME OF OEATH | | | | | | | |
| , | Francis | Kennedy | Wynne | | | Тапиан | 7 10 10 | 10, 1996 11:15 P | | | |
| | 4. SOCIAL SECURITY NUMBER | - | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIR | TH | | HPLACE (State or Foreign | | |
| | 579-05-4604 9a. FACILITY NAME (If not institution, give | | S1 YRS. | NTHS DAYS | HOURS MIN. | Feb. 25 | | Was | hington,DC | | |
| 5 | Calvert Memoria | | | | Freder | | 9c. COU | Cal | vert | | |
| 2 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUR | NTY | 10c. CITY. 1 | OWN OR LOCAT | ION | | | | 10d. INSIDE CITY | | |
| FUNERAL DIRECTOR | | tgomery | Avo | | | LIMITS? | | | | | |
| \$ | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | 10g. CIT | | WHAT COUNTRY? | | |
| | 5406 21st Plac | | | | 20782 | | | U. | S.A. | | |
| 10 L | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | ENDENT OF HISPAI city Cuban, Mexica 2 XNO Specif | n, Puerto Rican, e | E — American Indian, ik, Whita, etc. illy: | | | | |
| | | W.W.1 | | | | | | | hite | | |
| COMPLEIED | 15. DECEDENT'S El (Specify only highest gra Elementary/Secondary (0-12) | DUCATION ade completed) College (1-4 or 5+) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n | done during mo | IN st of working | 16b. KIND | OF BUSINESS/INC | DUSTRY | | | |
| Ę | 12 | | restaura | nt man | ager | 1 | restaura | ant | | | |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, I | Maiden Surname) | | | | |
| BEC | Thomas Wynne | | | | Adela | ide Parl | ker | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street a | nd Number or Rural | Floute Number, City | or Town, State, Zip | Code) | | | |
| = | Mary Goldman | | 5300 Ki | 814 | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Surial 2 Cycremation 3 Re 4 Donation 5 Other (Specify) | amoval from State cen | 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crematory or other place) Metropolitan Crematory Jan. 14,96 Alexandria, Va. | | | | | | | | |
| ļ | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| į | »() (O) | POD/16/1 | | | Funeral | | | | | | |
| | 23 PART i. Enter the diseases, o | 9 (10) | | | | | | | DC 20007 | | |
| | ahock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | |
| MEDICAL C | PART II. Other algnificent condition | PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DE | | | | | | | | | |
| | DID TOBACCO USE CON | ITRIBUTE TO CAUSE O | OF DEATH YES | □ NO/C | UNCERTAL | N 🗆 | ` | | | | |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH | | | | | | | | |
| 2 | 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Out | | THER: | e 5 🗆 Realdence | 6 Other (Spec | ily) | | | | |
| | 27, MANNER OF DEATH | 26a. DATE OF INJURY | 26b, TIME (| | URY AT | 26d. DESCRIBE | HOW INJURY OC | CURED | | | |
| 2 | 1 Natural 5 Pending | (Month, Day, Year) | INJUN | M 1 🗆 | | | | | | | |
| 2 | 3 Suicide 6 Could not I | 26e. PLACE OF INJUR' building, etc. (Spe | JRY — At home, term, street, factory, office | | | 261, LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| COMPLE | one) | YSICIAN: To the beet of my know | | | | | | | (a) and menner as stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIF | FIER | | | 29c. LICENSE NU | MBER | 29d. DAT | E SIGNE | D (Month, Day, Year) | | |
| 200 | 0 | Mardia | MM | | 242 | 176/0 298. DATE SIG | | | SNED (Month, Day, Year) | | |
| 2 | Dr. Dalla Tavalo Prince Freder (MD2017) | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | NATURE | | , , , | | | | .,, | | |
| FEB 01 1996 Julie Studger Revell | | | | | | | | | 1 | | |

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. ROX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | | | MENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | | | | | |
|------------------|--|--|--|---|-----------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH MONTH DAY | YEAR | 3. TIME OF DEATN | | | | |
| | | liams | | Jan. 18,19 | 96 | 5:30 P. M | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. $062-16-6324$ 1 \times M 2 \longrightarrow F 75 | _ | F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) August 11 | Count | NPLACE (State or Foreign ry) Carolina | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) | 9 | b. CITY, TOWN OR LOCATION OF DE | | 9c. COUNTY OF C | D. Gal Ollina | | | | |
| 8 | The Charter House | | Silver Spring | | | omery | | | | |
| <u>ا</u> ق | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | |
| DIRECTOR | Maryland Montgomery | | rown or Location ver Spring | | | 10d. INSIDE CITY LIMITS? | | | | |
| | 100. STREET AND NUMBER | 011 | 10f. ZIP CODE | T | 10g. CITIZEN OF | 1 YES 2 NO | | | | |
| M. | 1316 Fenwick Lane #511 | | 20910 | | U.S. | | | | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. | | 13. WAS DECENDENT OF HISPAN | | or No- 14. RAC | E — American Indian, | | | | |
| BY F | 1 | NO | It yes, specify Cuban, Mexical 1 ☐ YES 2 ☒ NO Specify | | b La | k, White, etc. | | | | |
| | | | | | | ick | | | | |
| | (Specify only highest grade completed) | (Give kind of world life, Do NOT use n | UAL OCCUPATION k done during most of working etired.) | 16b. KIND OF BUS | INESS/INDUSTRY | | | | | |
| 2 | College (1-4 or 5 +) | | specialist | Departm | net of L | ahor | | | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | Junp d C C I | | ME (First, Middle, Maiden S | | 14501 | | | | |
| BEC | Robert Todd Williams, Sr. | | Inez D | rew | | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | DORESS (Street and Number or Rural F | | | | | | | |
| - | Robert A. Gazzola | | St., N.W., #510, | | | | | | | |
| | 20e. METNOD OF DISPOSITION 1 Burlet 2 XI Cremation 3 Removal from State cemetary. | CEAND DATE OF I | oisposition(Neme of an Crematory Ja | DATE 20c. LOC | ATION - City or To | own, State | | | | |
| | 4 Donation 5 Other (Specify) MCT1 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | roportr | | | | a, va. | | | | |
| | 0 90000 | | DeVol Funeral | | | | | | | |
| | Semb Che Vol | | 2222 Wisconsi | | | | | | | |
| | 23. PARTY. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition resulting in death) e | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST e. CW d. A PURENTIAL TO SERVICE OF SERVICE | | | | | | | | | |
| AL | PART II. Other significant conditions contributing to death but no | at resulting in | the underlying ceuse given in | Part I. 24a. WAS AN / PERFORI | WERE AUTOPSY FINDINGS | | | | | |
| | | | | 1 YES 2 | X NO | COMPLETION OF CAUSE OF DEATH? | | | | |
| ME | | | = | | | 1 TYES 2 NO | | | | |
| AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DI | LACE OF DEATH | Oneck only one) | и 📗 | | | | | | |
| 딩 딩 | EXAMINER? 1 YES 2 XNO HOSPITAL: 1 Input lent 2 ER/Outpet lent | | THER: Nursing Home 5 Residence | 6 Char (Casally) | | | | | | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATN 25s. DATE OF INJURY 1 Shetural 5 Pending (Mogth, Pag. Veer) | 26b. TIME (| OF 28c. INJURY AT WORK? | 28d. DESCRIBE NOW IN | JURY OCCURED | | | | | |
| ВУ | 2 Accident Investigation 28e PLACE OF INJURY — At | home, tarm, stre | M 1 YES 2 NO | 261, LOCATION (Street a | nd Number or Pural | Route Number, | | | | |
| 品 | Suicide 6 Could not be determined building, stc. (Specify) | | | City or Town, State) | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: On the best of examination end. | | | | | a) and manner as stated. | | | | |
| TO BE | 296. SIGNATURE AND TITLE ON CERTIFIER (M) | | 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D44826 LGGE | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I | 20 Pc | iny It. #20 | 1-B Silv | er 80%, | my | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | () | | | | |
| | JAN 3 0 1996 Juli Davidson Ra | Mall | | | | V | | | | |

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| State of Maryland / Department of Health and Mental Hygi | ene 96 |) |

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death 25, 1996 **Physician** Brenda Joyce Wasko 12:20P. January /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRince George's 11904 Montague Drive Laurel If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Data of Birth (Month, Day, Year) August 28,1944 Birthplaca (State or Foreign Country)
 Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1□M 2XX Days Hours 51 Yrs. 178-34-8796 Director Usual Residence of Decedent e filed within 72 hours efter deeth with the Maryland el Hygiene.

other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits parmit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryle Department of Health and Mentel Hydene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, fra Medical Examiner must be notified anone. Maryland Prince George's Laurel 1 Tas 2000 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11904 Montague Drive 20708 United STates Funeral 12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Nevar Married Married 21215-0020 1 ☐ Yes 2XXIo Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry (Specify only highast grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Secretary Private Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Omer **Ethel** Brown Ditmore 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ralph W. Wasko, Sr. same as #10 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata XXBurial 2 Cremation 3 Removal from State Columbia Memorial Park 1/29/96 Columbia, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice License 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. wit. 4400 Powder Mill Rd. Beltsville, Md. 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a reach line. Approximata Interval Betw Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) CARDIO RESPIRATORY FAILURE
Due to (or es a consequence of): week Examiner Examiner PRIMARY DERTONEAL CARCINOMA The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury and Box 68760, physician Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 80 be deteched for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown yd bengis Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed should hes page 2 2XXX 1 ☐ Yes XX No certificate 1 Yes or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5XX esidence 6 Other (Specify) Certification: To 1 Yes 200No this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. fnjury et Work? After Veturel 5 Pending 1 Yes XX No deeth. investigation 2 ☐ Accident efter deetl Director: 6 Could not be determined 3 D Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. within 2 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Jahr Davidson Rardall JAN 30 1996 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Williams 12, Ethel 1996 Jan. 3:10 p. 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Merner Nursing Home Laurel If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Feb. 22 9. Birthplace (State or Foreign Deys Months 65 578-40-7248 1930 N. Carolina Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inaide City Limits Silver Spring 1 Yes 2 No Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1400 Fenwick Lane, #404 20910 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced Yeer or Detes 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic None 17. Fether's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Sumeme) Glenn L. Hedgepeth Mary E. Ricks 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 3995 Warner Ave., Landover Hill, MD 20784 Mary E. Walker 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from Stete Metropolitan Crematory 1/27 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility SNOWDEN FUNERAL HOME, P.A. ٤ 20850 ROCKVILLE, MD ter the mode of dying, such as cerdie Part . Enter the disease, or complications that caused the deeth. Do not en shock, or heart feiture. List only only cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Whohay Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest as e consequence of) uco Epider moid Carcinona Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? astatic Carcinoma 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 8 Could not be

/Medical Examiner Examiner The law requires that the death certificate be executed the buriel-transit and Box 68760, attending physician Physician/Medical P.O. the i signed by Division of Vital Records. þ Completed been : hes within 24 hours effect death.

To the Funeral Director: After this completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the comp this certificate Be Certification: To

Physician

Medical

Physician

/Medicai

Examiner

10a. State

Funeral Director

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Completed

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any Injury or other traumatic excessions.

tiero Sclerotic Cardio Vascular Juene 25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death 1 Neturai 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end manner as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner steted. 29a. Certifier (Check only one)

29b. Signature and title dicertifier

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Georgia #220, SILVER SIRING 901

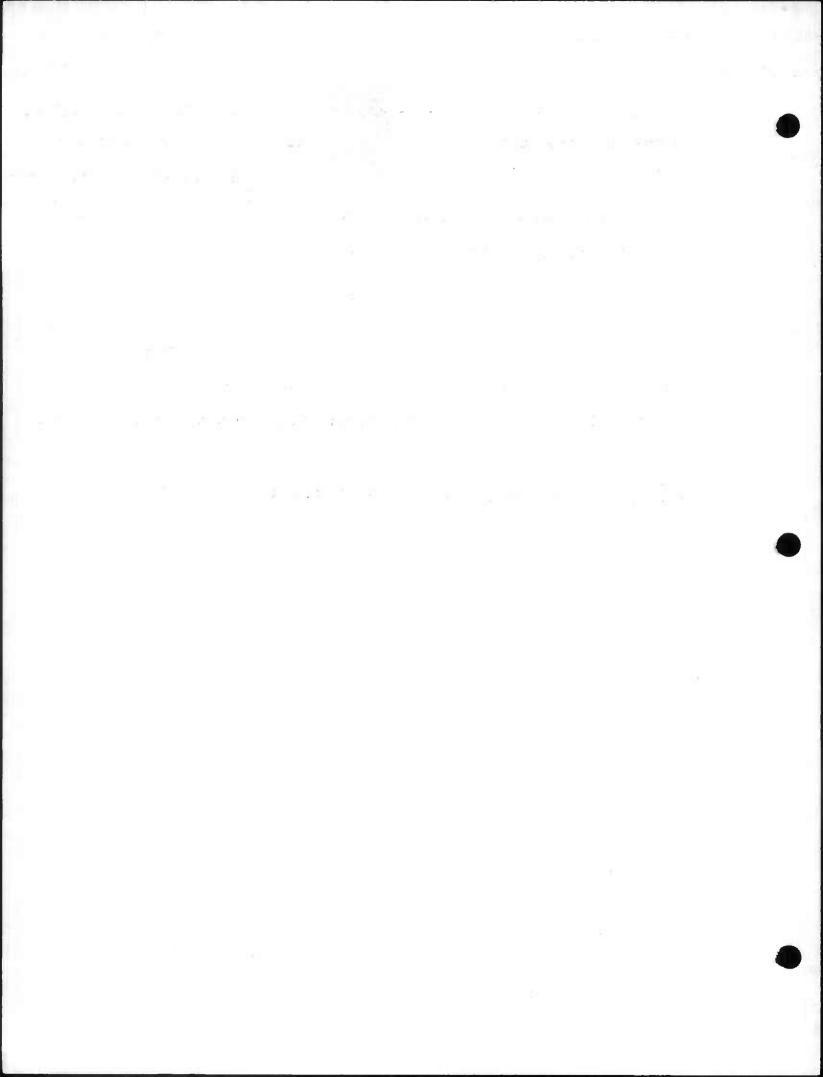
31. Dete filed (Month, Dey, Year)

JAN 29 1996

32. Registrer's Signeture Randall

State

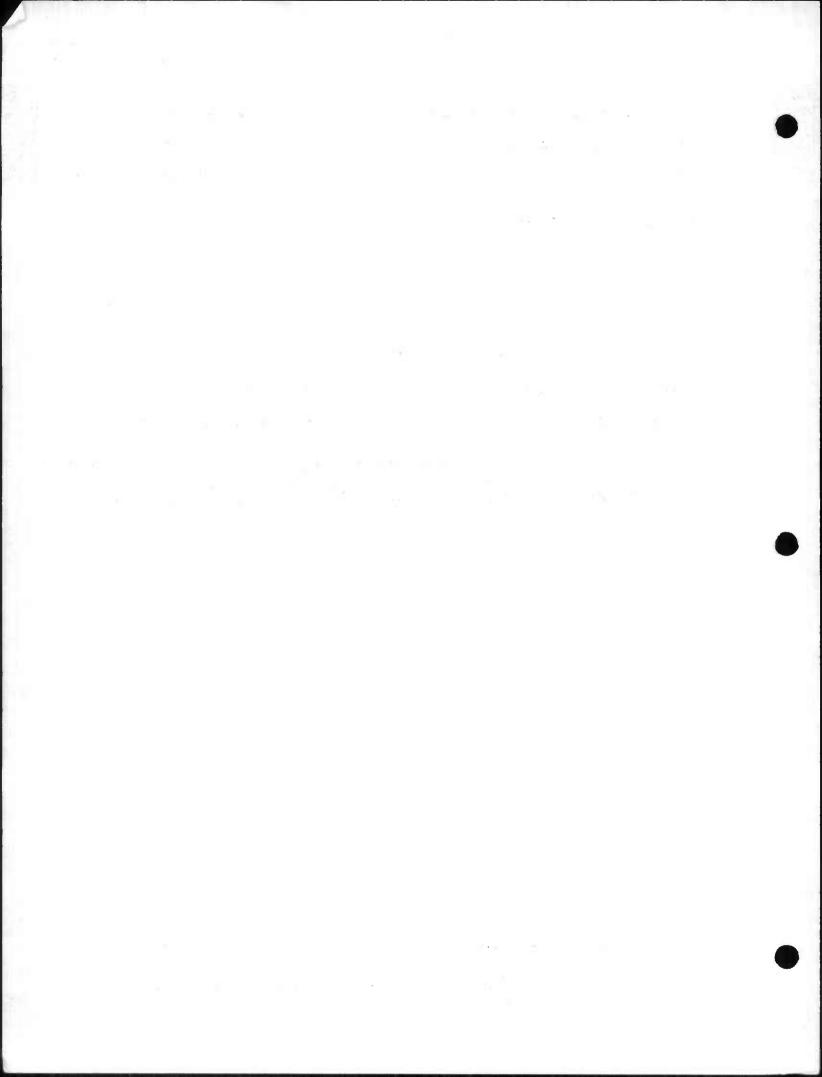
Registrar



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State of Maryland / Department of Health and Mental Hygien O.

| | | | | Citate of IVI | ai yiai i | | | | Death | R | eg. No. | 5 U | 3893 | |
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| | Dharini | | 1. Decedent's Name (First, Middla, La. | st) | | | | | | 2. Data of Dea Month | | Year | 3. Tima ot Dea | th |
| | Physic /Medi | | MARJORIE Ch | ampion W | ILLCO |)X | | | | JANUARY | | 996 | 4:30 | AN |
| | Examir | | 4e. Fecility Name (If not Institution, give | | | | | 4 | b. City, Town, or | Location of Death | 4c. County | | 1.70 | - 4-4- |
| | | Ш | Prince George's H | | | | | | Cheverly | | Princ | | orge's | |
| | Funeral Director | | 3/8-82-3346 | ax □ M aXXF | 9 (In yrs. I | last birthdey) Yrs. | If Undar Months | 1 Year Deys | If Under 24 Hrs Hours Min. | 8. Date of Birth (Month, Day Dec. 11 | Year) | 9. Birthp Coun Calif | iaca (Stata or Foi try) Ornia | eign |
| | yland | | Usuel Rasidanca of Decedant 10a. Stata 10b. County | | 10c. City | y, Town or Loc | ation | | | | | 1 | 0d. Insida City Lir | nits |
| | Mar | tor | Maryland Prince 0 | George's | Mit | chellv | ille | | | | | | 1 Yas 2 | No |
| | th th | Director | 10e. Street and Numbar | | | | 10f. Zip | Coda | | 1 | 0g. Citizen ot | What Coun | try? | |
| | 23a | ai | 10450 Lottsford F | Road, #401 | 5 | | 20 | 0721 | | | United | Stat | ces | |
| 21215-0020 | n 72 hours after death with the Maryland "natural", or liems 23a or 28=f show colcal Examiner must be notified at | by Funeral | 11. Meritei Status 1 □ Navar Married 2 □ Married 3 □ Widowad 4 □ Divorced | 12. Was Decedent Armed Forcas? 1 ☐ Yas 2000 If Yas, Give Yeer or Datas: | Ever In U, lo | | Ves Deced Yes, spec ☐ Yas 2 | | lispanic Origin? (S en, Maxican, Puer Specity: | specify Yas or No- to Rican, atc.) | | e - Americ ck, White, v: | etc. | |
| 0-10 | 72 hou | pel | 15. Decedant's Ed | | 16a, Dacedent's Usual Occupation | | | | | | 16b. Kind of B | | | |
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| | a filed withlest Hygiene. other than | Con | 12 | 5+ | " | Atto | rney | at | Law | | U.S. | Gove | nment | |
| pu | 0 2 0 | Be | 17. Fethar's Nama (First, Middle, Last) | | | | | | | ma (First, Middla, | Ma <i>idan Sum</i> an | na) | | |
| Mar | | L 2 | | pion | _ | | | | Edith | Dyer | | | | |
| | V 00 00 0 | | 19e. intormant's Name/Ralationship (1) Dana Willcox | Type, Print) | | | _ | - | | ural Routa Number | | | | |
| | | | Dana Willcox 20a. Mathod of Disposition | | 20h P | | | | | , Silver | Spring 20c. Location | | | |
| nor | nt of or or or or or or or or | | 1 ☐ Burial 2 🕽 (Cramation 3 ☐ | | | laca of Dispos emetery, cram | | | | | | | | |
| altimore, | permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other once. | | 4 ☐ Donation 5 ☐ Other (Specif) 21. Signature of Funeral Service Licen | | Che | esapeak | | | ory | 2-2-96 B | eltsvi. | lle, | Maryland | |
| Ba | Depa Impo any is | | Rapp Funeral Sérvices, P. A. 933 Gist Avenue, Silver Spring, MD 209 | | | | | | | | | | | |
| | | | 23a. Pert1. Entar tha disaesa, or comp shock, or heart tailura. List only | olications thet causad ona ceusa on aach lir | tha daath | n. Do not anta | r tha mode | a of dyln | g, such as cardia | or raspiratory arr | est, | I | Approximate interval Between | |
| | Physician /Medical Examiner | | Immediate Causa (Final disease or condition rasulting in death) Due to (or as a consequence of): | | | | | | | | | | |) |
| | | er | | | | | | | | | | 1 | | 7 |
| | d d ansit | mim | Sequantially list conditions, if any, leading to Immediate causa. Enter Underlying Causa (Disease or injury that imitated awants | | | | | | | | | | nam yo | 453 |
| o, | an an rial-tr | Exa | | | | | | | | | | | 2011/00 | 2 |
| 68760, | ificate be executed g physician and as the burial-transit | edicai | Causa (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): | | | | | | | | | | my Si | |
| - | \$ 0 a | m2" | | | | | | | | | | | | |
| Вох | death cer e attendir d for use | lan | d | | | | | | | | | | | |
| 0 | 0 0 0 | Physician/N | Part ii. Other significant conditions of | an in Part I. | 23b. Dld to | bacco usa co | ntributs to | the causs of de | ath? | | | | | |
| P.0. | that the de ted by the detached | | Prumo | nin | | | | | | 1 12 Y | 88 2 No | 3 Prob | ably 4 Unki | lown |
| ds | 8 68 | d by | (00D) | | | | | | | 24a. Was a | n autonsv | 24b. We | ra eutopsy findin | ns. |
| Vital Records, | aw requints been si | Completed | (000 | | | | | | | perfor | mad? | ava | illabla prior to npletion of cause leath? | _ |
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| ita | | Bec | 25. Was casa refarred to medical | | | | | | 26. Place of De | ath (Check only or | a) | | | |
| | 5 00 | To | axaminar? 1 ☐ Yas 2 ☑ No | Hospital: | nt 2 🗆 I | ER/Outpatient | 3 DO | A Oth | er: 4 Nursing H | loma 5 ☐ Raside | ence 6 Oth | ar (Specify | •) | |
| 0 | ng Ph fter thi | | 27. Mannar of Daath 12⊠Natural 5 ☐ Panding | 28a. Date of Injur (Month, Day | Year) | 28b. Time of Injury | 28 | Bc. Injun Worl | y at k? | 28d. Dascribe h | ow injury occur | red | | |
| Divis.on of | Attending or death. ector: After by the fune | cati | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be | | | | М | | Yas 2□No | | | | | |
| Div. | tal or At is after of al Direct ed in by | Certification: | 4 Homicide datarmined | 28a. Place of Injubulding, atc | iry - At ho . <i>(Specify</i> | ma, tarm, stre | et, tectory, | offica | | 28f. Location (Street end Number or Rural Routa Number, City or Town, State) | | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune. | edicai | 29a. Cartifiar 1 Cartifying Phy one) 2 ☐ Medical Exam | reician: To the best of iner: On the basis of and mannar sta | axaminati | viedga, daath ion and/or inva | occurred a astigation, | t tha tin | na, data and piece pinion, daath occu | , and dua to the corred at the time, d | ause(s) and ma ata and place, | nnar as st and dua to | ated. tha cause(s) | |
| | To the To the | Me | 29b. Signature and title of pertifier | - | | | 29c. | Licans | e number | 2 | 9d. Dete signe | d (Month, I | Dey, Year) | |
| | | | 1/1/2 | 255 | 7 | | 5 |) _ | 4/100 | 3 | 1/30 | 2791 | | |
| | | | 30, Name and address of person who o | ompleted causa of de | eth (Itam | 23a) (Type, F | Print) | | .607 | | , , | 1 - 1 | > | |
| _ | | | Radman mostagh | im 7305 | HA | HOVE | PKW | 14 | Cosunb. | 3 U (no | 203 | 9.0 | | |
| | Sta | | 31. Data filed (Month, Day, Year) | Registra | r's Signet | Redall | | | | | | | | |



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| | | | | State of Marylar | | tificate of | | | Reg. No. | 03 | 894 | | |
|--|---|----------------|---|--|------------------------|---------------------|---|---|--|------------------------------|--|--|--|
| | Physici | | Decedent's Neme (First, Middle, Last) Feng - Yen Yan | Q | | | | 2. Dete of Dee Month January | Dey | Year | 3. Time of Death 2:25 PM | | |
| ā | /Medi Examir | | 4e. Fecility Name (If not institution, give si | | 4b. City, Town, or I | | | | 2.25 FFI | | | | |
| | | | 14508 Holly Hock W | | Burtonsv | ille | Monts | omer | ·v | | | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Y | | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, De) | | | ece (Stete or Foreign ry) | | | |
| 7 | Director | | 215-33-6608 | M 2□ F 43 | Yrs. | Months Deys | Hours Min. | August | 1,1952 | Taiw | | | |
| fand | 8 m | | Usuel Residence of Decedent 10a. Stete 10b. County | 10c. Ci | ty, Town or Loc | eation | | | | 10 | d. fnside City Limits | | |
| Mary | 12 | to | Maryland Montgome | rv | Burtons | ville | | | 1 □ Yes 2 ☑ N | | | | |
| the the | should be miss within 72 hours site losed with the marylend Mentel Hygiene. The heart lead of the the "neturel", or items 23a or 28a-f show imeric event, the Medical Examiner must be not led at | Director | 10e. Street end Number | -7 | bur coms | 101. Zip Code | | | 10g. Citizen of W | het Count | ry? | | |
| the children of the children o | | | 14508 Holly Hock W | ay | | 2086 | 6 | | USA | | | | |
| dea | | Funeral | | 2. Wes Decedent Ever in U Armed Forces? | J,S. 13. W | es Decedent of F | lispenic Origin? (S en, Mexican, Puert | pecify Yes or No- | No- 14. Race - American Indien, Bieck, White, etc. | | | | |
| or of the | al', or is | by | 1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: | 1 ☐ Yes 2☑ No Specify: | | | o viloan, etc.) | | Asi | | | |
| d 2 should be filed within 72 hours at | ithin 72 ho 18. Ian "naturi Medical I | Completed | 15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12) | etion completed) College (1-4or 5+) | (Give k | | pation during most of wor d) | king | 16b. Kind of Business/Industry | | | | |
| N Dell | Hygiene. other than | | 17. Fether's Neme (First, Middle, Last) | | Cle | rk | 18 Mother's Nen | ne (First, Middle, | Wholesa | | | | |
| d be | ie marked of raumatic ever | To Be | Ah - Liang Yang | | | | | | | , | | | |
| should be | th end Mer 7 to marks traumatic | F | Ah - Liang Yang Lee - Pi Yang 19e. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip | | | | | | | | | | |
| | 27 le | | Su - Jung Yang | | | | ock Way, | | | | 0866 | | |
| 8 - 8 | ment of Health a ant: If item 27 le ury or other tra | | 20a. Method of Disposition | | Plece of Dispos | | 1 | Dete | | City or Town, State | | | |
| Peo | int: # | | 1 ☐ Buriel 2 🖾 Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify) | emover from Stete | | 40 1 | | 3/96 A | lexandri | a. I | 7A | | |
| permit. Peges 1 ar | Department of Important: If it any injury or conce. | | 4 Donetion 5 Other (Specify) Metropolitan Crematory 2/3/96 Alexandria, VA 21. Signeture of Fernical Service Licenses Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 2 | | | | | | | | | | |
| - | _ | | 23e. Part1. Enter the diseese, or complic shock, or heert feilure. List only one | etions that caused the deel | th. Do not ente | r the mode of dylr | rsity Bi | or respiretory er | Silver S | prin | Approximete Interval Between | | |
| - 1 | hysician Medical | | Immediate Cause (Final disease or condition resulting in death) Cachexia Due to (or as a consequence of): | | | | | | | | | | |
| E | xaminer | | | | | | | | | | | | |
| Ø | , tr | la la | a h | | | 3 | Years | | | | | | |
| ficete be executed | physician end s the buriel-transit | Examiner | Sequentially list conditions, if env. leeding to immediate | | | 1 | | | | | | | |
| 3 | siclan | | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | | | | | | | | | | |
| | 0.6 | /Medical | resulting in death) Lest | | | | | | | | | | |
| death cert | attending ; for use as | Physician/M | | | | | | | 1 | | | | |
| g | @ Y | ysi | Pert II. Other eignificant conditions contri | ibuting to death but not res | ulting In the un | derlying cause giv | en in Pert I. | | | | the cause of death? | | |
| thet | | by Pl | Massive_Ascites | | | | | 101 | ee 2□No | 3 Prob | ably 4 ☐ Unknow | | |
| Physician: The lew requires | should | Completed b | | | | | | 24e. Wes a perfor | | eva | re autopsy findings ilable prior to apletion of cause eath? | | |
| The le | E 80 | E | | | | | | 1□∨ | es 2 🛮 No | | Yes 2□ No | | |
| an: | certificate rector, pag | Bec | 25. Wes case referred to medical | | | | 26. Piece of Dee | oth (Check only or | | | 100 20 110 | | |
| Physician: | is certific director, | ToE | examiner? 1 ☐ Yes 2 ☑ No | ospitel: | ER/Outpatient | 3□ DOA Oth | or. | ome 512 Resid | | (Specify |) | | |
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| Attending | death. ctor: After y the funer | Satic | 2 ☐ Accident Investigation | | ,, | | Yes 2 □ No | | | | | | |
| al or Attending | s after d | Certification: | 3 Suicide 6 Could not be determined | 28e. Piece of Injury - At he building, etc. (Specif | ome, ferm, stre | et, fectory, office | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| Me Hospit | within 24 hours after death. To the Funeral Director: A completely filled in by the fi | edical | | clan: To the best of my kno er: On the besis of examine end menner steted. | | | | | | | | | |
| To th | To the | Me | 29b. Signeture and title of cartifler | 0 | | 29c. Licens | e number | 2 | 29d. Dete signed | (Month, E | ay, Year) | | |
| | | | June n. I | ue do | | D | 26707 | | February 1, 1996 | | | | |
| | | | 30. Neme end eddress of person who com | pleted cause of deeth (Item | n 23a) (Type, P | rint) | | | | -, | | | |
| | | | Tung-Pi Lee M.D. 70 | | | , Silver | Spring, | MD 2090 | 1-3613 | | | | |
| | Sta Registr | | 31. Dete flied (Month, Dey, Year) FEB 02 1996 | 32. Registrer's Signature of the street of t | ture | | | | | | | | |

DHMH 16 Rev 6/95

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR

1 -

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| 1. DECEDENT'S NAME (First | t, Middle, Last) | | | | | | | TE OF DEATH | W | VEAD 3 | 3. TIME OF DEATH |
|--|----------------------------------|---|---------------------------|---|----------------|-------------------|-----------------------|---|--|------------|--|
| | | r Zeller | S | | | | Ja | n. 24, | 199 | 6 2 | 2:00A M |
| 4. SOCIAL SECURITY NUMBER 217-03-98 | | 5. SEX 1 XM 2 F | AGE (In yrs. 81 | | NTHS DAY | | s. 7. DA (MC MA | Y 17,1 | 914 | Country) | RYLAND |
| 9e. FACILITY NAME (If not in | | | | | | N OR LOCATION OF | | | 9c. COUNT | Y OF DEA | ATH |
| CHESTERTO | CEDENT | JRSING/RI | ЕНАВ. | CENTE | R | CHESTER | MOT | 1 | KF | ENT | |
| MARYLAND | CAR | DLINE | | 10c. CITY, T | OWN OR LO | | | | 10d, INSIDE CI LIMITS? 1 YES 24 | | |
| 10e. STREET AND NUMBER | | | | | T | 10f. ZIP CODE | | | 10g. CITIZI | | AT COUNTRY? |
| 21405 TAI | NYARD | | | | | | 655 | | | USA | |
| 1 Never Married 2 3 XWidowed 4 Divo | | 12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR | YES 2 | 2 NO If yes, specify Cuban, Mexican, Puerto Rican | | | | | y Yee or No— 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| | EDENT'S EDUC ly highest grade | | | DECEDENT'S USI | done during | | 1 | 6b. KIND OF BUS | SINESS/INDU | STRY | |
| Elementary/Secondary (t | 0-12) | College (1-4 or 5+) | | PRESS | | ATOR | | COMMU | NICAT | 'ION | s |
| 17. FATHER'S NAME (First, M | fiddle, Lest) | | | | | 18. MOTHER'S | NAME (Firs | t, Middle, Malden | Surname) | | |
| JOHN HEN | | LLERS | | | | | | IA KLI | | | |
| WILLIAM I | | LELRS | | | | ARD ROA | | | | | 655 |
| 20a METHOD OF DISPOSIT | TON | wal from State | | EANDDATEOFD | | (Name of | D | ATE 20c. LO | CATION — CI | ty or Town | n, State |
| 4 Donation 5 Other | (Specify) | | | ORDER | | ETERY | 1-2 | 27 PR | ESTON | . M | D |
| 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | | | | AND ADDRESS OF | | HOME | D 3 | | |
| ZOHA | S C | MERCE | RON | CFSP | | NAM FUN S. HAR | | | | | . MD |
| 23. PART i. Enter the d | iseasee, or c | omplications that ca lat only one cause | on each ii | death. Do not | | moda of dying, s | uch ss c | ardisc or respi | ratory srre | et, | Approximate interval Between |
| IMMEDIATE CAUSE (Fir disease or condition resulting in dasth) | | DUE TO (OR | | EOUENCE OF): | | | | | | | Onset and Deeth |
| Sequentially list condit if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in death) LAS | diata ING Iry | | | EOUENCE OF): | | | | | | | |
| PART II. Other significe | ent condition | s contributing to de | eth but not | resulting in t | he undari | /ing cause givan | in Part i. | 24a. WAS AN PERFOR | | | VERE AUTOPSY FINDINGS WAILABLE PRIOR TO |
| COCODAC | parte | Ty drseas | 9. | | | | | 1 TYES 2 | NO | | OMPLETION OF CAUSE OF DEATH? |
| congesti | | ert teilur | 2 | | | | | f | | 1 | YES 2 NO |
| DID TOBACCO U | | RIBUTE TO CAUS | | ATH YES | | | AIN 🔲 | | | | |
| EXAMINER? | O MEDICAL | HOSPITAL: | | 0 | THEA: | | 0 0 | | | | |
| 27. MANNED OF DEATH | | 26s. DATE OF INJ | URY | 28b. TIME O | F 28c. | iome 5 Residen | _ | ter (Specify) | NJURY OCCU | RED | |
| | Pending Investigation | (Month, Day,) | fear) | INJURY | | WORK? YES 2 NO | | | | | |
| 3 Sufcide 6 | Could not be | 26s. PLACE OF IN buffding, etc. | IJURY — At I (Specify) | nome, ferm, atree | et, factory, o | ffice | 28f. LC | OCATION (Street a ty or Town, State) | nd Number of | Rural Rou | ite Number, |
| anal | | CIAN: To the best of my | | | | | | | | | nd manner as stated. |
| 29b. SIGNATURE AND TITLE | OF CERTIFIER | _ | nn, | | | 29c. LICENSE I | NUMBER | | 29d. DATE | SIGNED (N | fonth, Day, Year) |
| | 34 | Brown | Gall 1 | do | | 033 | 515 | / | | | -96 |
| 30. NAME AND ADDRESS OF | F PERSON WHO | COMPLETED CAUSE C | OF DEATH (IT | EM 27) (Type, Prin | nt) | | | | | | , |
| Dr.Mich | ael B | ienenfel | a Me | dical | Bldo | . Chest | tert | own. M | arvl | and | 21620 |
| JAN 26 | Year) | 32. REGISTRAR'S | SIGNATURE | | | | | | - | | |
| | | ," | | | | | | | | | |

ITEN: 11. PER INFORMANT FILM State of Maryland / Department of Health and Mental Hygiene 9 6 G-732 2/29/96 t.t Certificate of Death 1. Decedant's Nama (First, Middia, Last) 2. Data of Death 3. Time of Death **Physician** all /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Daya Houra 10XM 2□ F 217-25-7868 Yrs Director 86 May 24, 1909 Ukraine Usual Rasidance of Dacedant with the Meryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryla Department of Haelith end Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahov any Injury or other traumatic event, the Medical Examiner must be notified at once. MD Montgomery 1 √ Yas 2 No Director Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20902 1135 University Blvd. West Apt. 201 Russia Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas; 1 Nevar Married 2 Married 1 ☐ Yas 2 No ģ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) Mechanical Engineer Engineering 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Moshe Zhitomirsky Polonskaya Mindlya 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1001 Rockville Pike Apt.605, Rockville, MD 20852 Valentin Koretsky/ Grandson 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 █ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 1/28 Judean Memorial Gardens Olney, MD 21. Signature of Funeral Se rylce/Licensee 22. Nama and Addrass of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, MD 20852 Arr oximata Inta al Between Onset and Death Part — Entur the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Examiner 8 that the death certificeta be assecuted physician and s the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Diseasa or Injury that Initiated events rasulting in daath) Last Dua to (or as a consequence of). Physician/Medicai Dua to (or as a consequence of): 50 980 ò Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. detached 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No signed t by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 s has 2 No 1 Tas 1 ☐ Yas 2 ☐ No certificate funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) 1 Yas 27 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1) Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Panding Invastigation or Attending 1 Natural Accidant 24 hours after death. Funeral Director: At 1 Yas 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Sulcida 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homleide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifia To the Hosp within 24 ho To the Fund completely f (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) phoeni

State Registrar 31. Data filed (Month, Day, Year)

IRENDRA

30. Name and addrass of person who completed cause of death (Item 23a) (Type) Print)

32. Registrar's Signatura

susursan Hornera

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Par | "THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral of | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlar, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examine |
| 5 | 早 | 2 | = |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO t, DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN MONTH 2 AKIN -AURA 2.53 PM 1996 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Dey, Year) 5 SEY IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 268-16-6566 77 1 M 2 V F Pennsylvania 03 -16 Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Howard County General Hospital Columbia Howard County DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY Howard County Maryland Ellicott City 1 YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? FUNERAL 3354-I North Chatham Road USA 21042 ti. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES TO NO It yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: t Never Married 2 Married Specify BY 3X Widowed 4 Divorced white COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Bakery once. 17. FATNER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First Middle Maiden Surname) Hugh Reynolds Drucilla Markle 7 notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Terry K. Akin /son 3354-I North Chatham Rd., Ellicott City, MD 21042 9 20a. METHOD OF DISPOSITION
1.XX Burlal 2. Cremation 3.XX Bemoval Inc. 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE must Union Cemetery 2-16 Greensburg, PA 4 Donetti Other (Specify) examiner REAR FUNERAL SERVICE LICENSE 22. NAME AND ADORESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Maryland 21043 M00535 medicai 23. PATT I. Enter the diseases, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line. Onaet and Death IMMEDIATE CAUSE (Final the Myocardial Infarction disease or condition _____ acute mmediate marked, or item 23 shows any injury, or other traumatic event, OUE TO (OR AS A CONSTIQUENCE OF) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Pulmonay AVAILABLE PRIOR TO Dissone Obstriction COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL: 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Rasidenca 6 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28a. OATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 1 Natural 5 Pending BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide item 28 is COMPLETED 6 Could not be 4 Nomicide determined 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

nician

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FARRELLMD

32. REGISTRAR'S SIGNATURE

83

11055 Little Paturent Pkmy,

2-12-96

Columbia

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DNMH-16 Rev 1/89

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BERNARD

31. DATE FILEO (Month, Day, Year) FEB

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| | 1 - STATE REGISTRAR | | STATE OF I | C | EHIIF | ICATE U | F DEATH | | REG. NO. | | | |
|---|--|---|---|---|--|--|--|--|--|---|---------------------------------|--|
| 1 | 1. DECEOENT'S NAME | | | | | | | 2. DATE | OF DEATH | v | YEAR | 3. TIME OF DEATH |
| | Ronnie A | | | | | | | Fel | ruas | | 1996 | . 10:58 |
| | 4. SOCIAL SECURITY | | 5. SEX | 6. AGE (In yrs. le | | IF UNDER 1 YEAR | | 44.4 | OF BIRTH | 0 | BIRTHP Country | LACE (State or Foreign |
| | 214-22-6 | | 1 M 2 - F | 6 | 8 YRS. | MONTHS DAY | A HOURS MIN. | | ember | 1.19 | | NC |
| | 90. FACILITY NAME (# | | | | | 9b. CITY, TOW | N OR LOCATION OF | | | | TY OF DE | |
| E | Medical | | er | | |] | Baltimo | re | | | n/ | 'a |
| DIRECTOR | RESIDENCE OF | 10b. COUNT | | | Laston | Y. TOWN OR LO | | | | | | |
| Ë | MD | los. cooki | n/a | | | , | | | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NU | Heep | 11/α | | | altimo | | | | | | 1 YES 2 NO |
| FUNERAL | 1 | | ale St. | | | i | 101. ZIP CODE | 2 | | | | HAT COUNTRY? |
| 밀 | 11. MARITAL STATUS | . Dally | | | | | 2121 | | | | USA | |
| BY FU | 1 Never Married 3 Widowed 4 | - | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | RMED NO | If yes, | DECENDENT OF HISP , specify Cuban, Mex YES 2 WO Spe | ican, Puerto | t? (Specify Yee Ricen, atc.) | or No — | 14. RACE - Black, Specify | - American Indian, White, atc. |
| | 15 | S. DECEDENT'S EDU | UCATION | 16a. D | ECEDENT'S | USUAL OCCUPA | ATION | 16b | KIND OF BUS | /NESS/IND | LISTRY | DIACK |
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| 릴 | 6th | , (0, | Comage (1-4 of 5 | | lect. | riciar | n | | Self E | lmn1 | oved | |
| COMPL | 17. FATHER'S NAME (F | First, Middle, Last) | | | | | 18. MOTHER'S | | | | oyee | |
| Ш | Calvin | Atkin | son | | | | | la ur | | | | |
| 00 | 190. INFORMANT'S NA | AME (Type/Print) | | 15 | 9b. MAILING | ADDRESS (Street | et end Number or Run | | | State Zin | Code) | |
| 2 | Joann | Drake | | | | | ngs Ct. | | | | 2120 | 1 |
| 1 1 | -300, METHOD OF DISE | POSITION | | | | FDISPOSITION | | OAT | | | City or Tow | |
| 1 | 4 Donation 5 | Other (Specify) | noval from State | cemetery, cr | ematory or ot | har place) | | 1 | | | only or row | |
| | as modernie of the | | | _ Karr | ison | Fores | s+ VA | 2/ | /16 C | Tri n | cre M | 1110 M |
| | are productione of Fo | INERAL SERVICE LI | CENSEE | - Garr | ison | 22. NAME | ST VA | FACILITY | | | | |
| 15 | 1 1 - | | CENSEE | Garr | ison | Jan | nes A. I | FACILITY Morto | n & S | ons | Fun | eral Ho |
| | Va | mes C | 1. Wi | ulor |) | Jan 170 | nes A. 1 | Morto | n & S Stree | ons | Fun alto | eral Ho |
| | 23. PART I./Enter t | mes C | 1. Wi | t caused the d | eath. Do n | Jan 170 | nes A. 1 | Morto | n & S Stree | ons | Fun alto | eral Hor., MD |
| | 23. PART I thirter to thock, IMMEDIATE CAUSI | the diseases, or or heart failure. | complications the | t caused tha dise on each lin | aath. Do n | Jan 170 | AND ADDRESS OF MES A. 1 D1 Laure mode of dying, so | Morto | n & S Stree | ons | Fun alto | eral Hon |
| | 23. PART Literer to book, | the diseases, or or heart failure. | complications the | t caused tha dise on each lin | aath. Do n | Jan 170 | AND ADDRESS OF MES A. 1 D1 Laure mode of dying, so | Morto | n & S Stree | ons | Fun alto | eral Hoi ., MD |
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| NO | 23. PART Literer to cock, IMMEDIATE CAUSI disease or condition resulting in death) Sequentially list or | the diseases, or or haart failure. | complications the List only one cause. DUE TO | t caused tha dise on each line (OR AS A CONSE | eath. Do na. | 22. NAME Jan 170 oot enter the r | AND ADDRESS OF MES A. 1 D1 Laure mode of dying, so | Morto | n & S Stree | ons | Fun alto | eral Honor MD Approximate Interval Betwee Onset and Dec |
| ATION | 23. PART I limer to nock, IMMEDIATE CAUSI disease or condition resulting in death) Sequentially list or if any, leading to it | the diseases, or or heart failure. | complications the List only one cause. DUE TO | t caused tha dise on each lin | eath. Do na. | 22. NAME Jan 170 oot enter the r | AND ADDRESS OF MES A. 1 D1 Laure mode of dying, so | Morto | n & S Stree | ons | Fun alto | eral Honor MD Approximate Interval Betwee Onset and Dec |
| FICATION | 23. PART Literer to hock, IMMEDIATE CAUSI disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter UNDE CAUSE (Disease or CAUSE (Dise | the diseases, or or haart failure. E (Final on | complications has List only one cau | t caused tha dise on each line (OR AS A CONSE | eath. Do na. | 22. NAME Jan 170 oot enter the r | AND ADDRESS OF MES A. 1 D1 Laure mode of dying, so | Morto | n & S Stree | ons | Fun alto | eral Hon |
| CATION | 23. PART Liter to lock, IMMEDIATE CAUSI disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter UNDE | the diseases, or or heart failure. E (Final on —) onditions, mmediata ERLYING r Injury ts | complications has List only one cau | t caused tha dise on each line (OR AS A CONSE | eath. Do na. | 22. NAME Jan 170 oot enter the r | AND ADDRESS OF MES A. 1 D1 Laure mode of dying, so | Morto | n & S Stree | ons | Fun alto | eral Honor MD Approximate Interval Betwee Onset and Dec |
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| CERTIFI | 23. PART Literer to nock, IMMEDIATE CAUSI disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter UNDE CAUSE (Disease or that initiated even ini | the diseases, or or haart failure. E (Final on —) onditions, mmediata ERLYING or in jury ts | complications has Liet only one cause of the Liet on Liet on the Liet on | t caused the dise on each line (OR AS A CONSE | aath. Do na. | 22. NAME Jan 170 oot enter the r | eand address of mes A. I DI Laure mode of dying, st | FACILITY Mortcen s uch ss care //////////////////////////////////// | on & S Stree | ons t Batory arm | Funal to | eral Holo, MD Approximata interval Betwee Onset and Dec |
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Asker

1996

132. AMC
132. AMSTRAR'S SENTURE
1.22. AUNISON—MINDER

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2120

MD

24

10 N GREENE

TO BE

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Mary Arduin Feb. 7, 1996 1:55 AM /Medical 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Balto. City Harford Gardens Nursing Home Balto. City If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M DOF 215-16-2502 Yrs. Director 89 Oct. 18,1906 Italy Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Director 15 Yes 2 No Balto. City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 451 W. 24th Street 21211 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meditel Status 14. Race - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter of health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or item inty or other traumatic event, the Medical Examiner inty or other traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) In Own Home Homemaker 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Surnama) Be Michael Angelo Elmo Rosa Malicia 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) James Arduin 451 W. 24th Street Balto., MD 21211 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal Irom State Department of Important: If any injury or Office. New Cathedral Cemetery 2/10 4 ☐ Donation 5 ☐ Other (Spacify) Baltimore, Maryland 22. Name end Address of Facility
Burgee-Henss Funeral Home 21. Signature of Funerel Service Licensee 3631 Falls Road Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that reused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on anoth line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final L 20 mm disease or condition resulting in deeth) Examiner Examiner yrus burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last YMS AUTENIO SC physician the buria on of Vital Records, P.O. Box 68760 Physician/Medical 88 080 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part 1. been signed by the a should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENT! A þ 24b. Were autopsy findinga evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 X No 1 ☐ Yes 2 ☐ No certificate iding Physician: director. 25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Silli 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attor 1 XNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Director: 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide è 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end manner as atated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 28 within 2 To the 8 29b. Signature and tilled certiller 29c. License number 29d. Date signed (Month, Day, Year) 2. 8 D 24276 30 Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 2200 ISA-OTTHE ST 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

FEB 1 4 1996

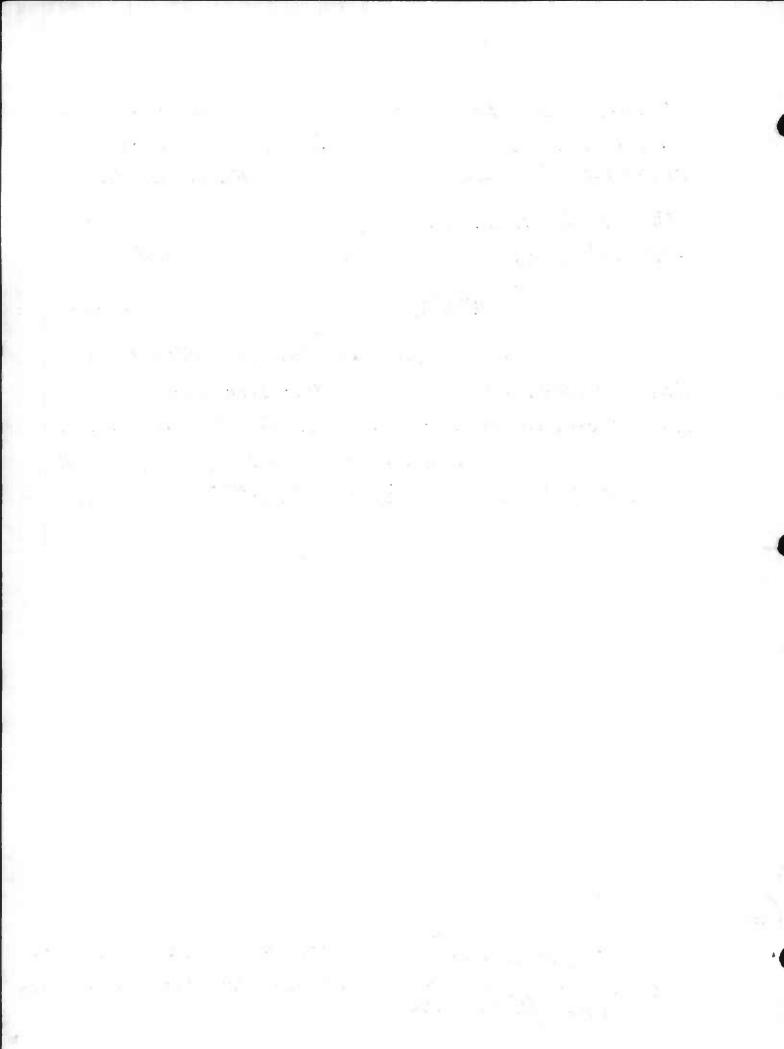
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 6 03900

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|----------|--|------------------|---|--|--|--|--|--------------------------------------|------------------------------|--|
| | Dhysisi | | 1. Decedent's Name (First, Middle, Last) | 1 2 1 - | | | 2. Date of Deat | h | Year | 3. Time of Death |
| | Physici /Medic | | Gilbert Ceci | Bond, JK | , | | Janya | 1251 | 1996 | unknows |
| | Examir | | 4a. Facility Neme (If not Institution, give street | and number) | | 4b. City, Town, or Le | ocation of Death | 4c. County of | Death | |
| | | | 3717 YOLANDO K | d . | M Haday d Wass | BAITIMO | 1. | Ch | 4 | |
| | Funeral Director | | 5. Social Security Number 2.13 - 94 - 5060 Usual Residence of Decedant | 7. Aga (In yrs. last birthday) 7. Aga (In yrs. last birthday) 7. Yrs. | If Under 1 Yeer Months Days | | 8. Dete of Birth (Month, Day, | Year) 1,1963 | Birthplace Country | a (State or Foreign |
| | anylend show | | 10a. Stata 10b. County | 10c. City, Town or Lo | cation | | | | 10d. | . Insida City Limits |
| | Man | tor | MD BALTIMER | ocity BA/tix | noRe | | | | | 10 Yas 2 No |
| | y 284 | Funeral Director | 10e. Street and Number | 1 | 10f. Zip Coda | | 10 | g. Citizen of Wh | net Country | ? |
| | th wil | ai D | 3717 YOLANDO R | \checkmark | 2121 | 18 | | USA | | |
| | r dea | neu | | as Decedant Ever in U,S. 13. 13. 1 | Was Decedent of I | Hispanic Origin? (Sp pan, Maxican, Puerto | ecify Yas or No- Rican, etc.) | | - Amarican White, etc | |
| 20 | 72 hours after death with the Maryland natural, or items 23s or 28s-f show dies Examiner must be notified at | | 1 Nevar Married 2 Married | Yes 2 No | 1 Yas 2 No | | , , , , , , | Specify: | 12/1 | ·V |
| 8 | 72 hours natural', | d by | 3 ☐ Widowed 4 ☐ Divorced Ÿ | ar or Datas: Nov 24,1986 | 4 | | | | BIA | <u> </u> |
| 215-0020 | S | Completed | (Spacify only highast grade com | olated) (Giva | kind of work dona DO NOT usa ratire | pation during most of worked) | ing | 16b. Kind of Bus | inass/indus | try |
| 212 | | шо | Elamantary/Secondery (0-12) Co | Haga (1740f 5+) | ectiona | / | el s | State 1 | Pri 50, | N |
| and | 0 = 0 = | BeC | 17. Fether's Nema (First, Middle, Last) | | | 18. Mothar's Nam | a (First, Middla, N | fa <i>id</i> an <i>Suma</i> me, | | |
| Vlai | Menta Menta Brked Bric ev | ToE | Gilbert C. Bond | 5R | | Elizab | eth L | ee | | |
| Mary | 2 sh end le m | | 19e. Intormant's Name/Relationship (Type, Pr | int) 19b. Mailir | ng Address (Street | t and Number or Rur | al Routa Number, | City or Town, S | tate, Zip Co | oda) |
| - 84 | s 1 and f Health frem 27 other tr | | 6. bert C. Bond Sr. | / Father 416 | Village | | | prace, | mp | 2018 |
| altimore | of to | | 20a. Method of Disposition 1月 Burial 2 ☐ Cramation 3 ☐ Ramov | 20b. Placa of Dispo cematary, cren | | , , , | | 20c. Location - C | ity or Town | , Stata |
| tim | P 4 2 | | 4 □ Donation 5 □ Other (Specify) | 6 arrison | rokest | let. Cem 1 | 1-30-96 6 | WING5 | Mill | 5 MD. |
| Bal | Departs Departs mports any inj | | 21. Signature of Fuperal Zervice/Licenses | 22 | Name end Addre | ass of Facility | Hom E | , | | |
| | | | Joen / le/for | 1 3 | 552 Le | wist H | zure di | | 7 | 1D |
| | Sec. 11554 | | shock, or heert tailura. List only ona cau | s that caused the deeth. Do not ant sa on each lina. | er the mode of dyi | ng, such es cerdiac | or respiratory arre | est, | In | pproximata tarval Between neet and Death |
| 0 | ≗n,⇔can /Medical | | Immediata Causa (Final | 1/2 to: | 9. | 0 | | | | neet and Death |
| | Examiner | | disease or condition rasulting in death) | vasieing | - 0gs | Laco. | ne. | | | |
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| | be executed sictan and buriel-transit | Examiner | Sequentially list conditions. | Due to (or as a conseq | uence of): | muse | 2 | crenc | 4 | |
| 0, | e exe | | Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disassa or Injury | tuman M | m mu | LO GER | icienc | Vin | 4 | |
| 68760, | ate of the | edical | that Initiated avants resulting In deeth) Last | Due to (or es e conseq | uance of): | 7 | (| 7 | 0 | |
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| Δ. | that the ded by | | | | | | 1 Y | 8 2□ No 3 | 3 ☐ Probet | oly 4 Unknown |
| Records, | 8 68 | d by | | | | | 24a. Was ai | autopsy | 24b. Wara | autopsy findings |
| 00 | w require been si should | Completed | | | | | perform | ned? | | ble prior to lation of cause |
| Re | The law ate hes b page 2 s | E | | | | | 1 □ Ye | s 25 No | | ′as 2□No |
| ta | | BeC | 25. Was casa ratarred to medicel | | | 26. Place of Deat | | | | as 20140 |
| of Vital | 00 | ToE | axaminar? 1 ☐ Yas 25146 Hospite | l: 1 ☐ Inpatient 2 ☐ ER/Outpatien | t 3 DOA Ot | han | ma 5 A Hesida | | (Specify) | |
| | fing Ph After thi funeral | | 27. Mannar of Death 28a 1 DNatural 5 □ Panding | Data of Injury 28b. Tima of (Month, Day Year) Injury | 28c. Inju Wo | ry at | 28d. Describe ho | w Injury occurred | d | |
| Division | Attending or death. | Certification: | 2 Accidant investigation 3 Sulcida 6 Could not be | | M 1□ | Yas 2□No | | | | |
| Ĭ. | or Attendation description of Attendation description of the descripti | E I | 4 Homicida datarmined 286 | Place of Injury - At homa, farm, streen building, atc. (Specify) | eat, factory, office | | 28t. Location (Sti City or Town | reet and Number , Stata) | or Rural R | outa Number, |
| ш | 4519 | | 29a, Cartifiar 1 Contifying Physician: | To the heat of multi-surface of the | and the state of | | amal algorithm of the | unadat : | | |
| 1 | FAT. | edical | (Check only 2 Medical Examiner: O | To the best of my knowledge, death the bests of examination and/or invided manner stated. | astigation, in my | ma, data and placa, opinion, daath occuri | end dua to tha ca red at tha tima, da | use(s) and mani ita and placa, an | nar as state id dua to th | a cause(s) |
| 1 | o the | Me | 29b. Signeture and titla of certifier | | 29ç. Licens | se number | 25 | d. Date signed | (Month, De | y, Year) |
| | 90 | | CA Co | concerts | DI | 4108 | - = | olen - | , 1 | 71991 |
| | (- | | 30. Nama and addrass of person who complate | ed causa ot daath (Itam 23a) (Type. | Print) | 1100 | / | w wa | 7h | 3 116 |
| | \vee | | DA DACA | es mb | 175 | 9 Que | STN | wu | BSK | 3 1996 |
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State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Cen | tificate of | Death | | | Reg. No. | | |
|------------|--|----------------|---|--|---------------------------------|-----------------------------|---|------------------------------|--------------------------|--|-----------------------------------|-------------------------------|---|
| | Physic /Medi | | 1. Decedent's Neme (First, Middle, I | LNST | Brov. | SSA | 10 | | | 2. Dete of De Month | Dey 14(2 | 1996 | 3. Time of Deeth |
| | Exami | ner | 4a. Facility Neme (If not institution, g Carroll Con | | | 1 | | 4b. City, To Westm: | | cation of Deet | | y of Death | |
| | Funeral Director | | 5. Sociel Security Number 6. 034–18–0062 | | ge (In yrs. last | | If Under 1 Year Months Deys | If Under | | 8. Dete of Bir (Month, De Dec. 4 | th by, Year) | 9. Birthpi Coun | iece (Stete or Foreign try) achusetts |
| | and | | Usuel Residence of Decedent 10e. Stete 10b. County | | 10c. City, T | own or Loc | ation | | | | | 10 | 0d. inside City Limits |
| | ter death with the Manylan Items 23a or 28e-f ehow Inet must be notified at | Director | Md. Carrol: | L | Fi | nksbu | 10f. Zip Code | | | | 10- Ohi | | 1 ☐ Yes 2 No |
| | Sa or | | 4102 Sykesvi | lle Road | | | 21048 | | | | 10g. Citizen of U.S. | | try r |
| 20 | 72 hours after death with the Maryland natural, or items 23s or 28s-f show area Examerer must be notified at | by Funeral | 11. Maritel Status 1 Never Married MMarried 3 Widowed 4 Divorced | 12. Wes Decedent Armed Forces: 1 Tyes 2 If Yes, Give Yeer or Detes: | P No | | res Decedent of Yes, specify Cut | | | ecify Yes or No Rican, etc.) | | ce - America eck, White, e | etc. |
| 8 | n 72 hours natural', | | 15. Decedent's | 1 | | 6a. Decede | ent's Usuei Occu | pation | | | 16b. Kind of E | | |
| 21215-0020 | | Completed | (Specify only highest g Eiementery/Secondery (0-12) | rade completed) College (1-4or | | (Give k | ind of work done O NOT use retire | during mos | t of worki | ng | | | |
| 2 | tiled within Hygiene. ther than | Com | 12 | 4 | 547 | Medi | cal Tec | hnicia | an | | Medic | al La | bs. |
| Maryland | | Be | 17. Father's Neme (First, Middle, Las | • | | | | | | 1 | , Meiden Sume | me) | |
| 7 | | To | Joseph E. Bro | | | | | | es Fo | | | | |
| Ma | ta en | | 19e. Informant's Neme/Rejetionship Margaret L. Brot | | | | Address (Stree Sykesvil | | | | | | Code) |
| ē, | Hea tem other | | 20e. Method of Disposition | ADDUX W | | | ition (Neme of etory or other pla | | . , | Dete | 20c. Location | | wn, Stete |
| DE OFF | Pages nent of I int: If its | | 1 ☐ Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec | | | | | | Feb. | 16. 1 | 996 Owi | ngs M | ills, Md. |
| Baltimore, | permit. Page: Department of Important: If I any Injury or once. | | 21. Signature of Funesal Service Lice | 0 0 | 1 | 22. E.C | Neme end Addr | ess of Fecilit | y al Ch | nanel | | | |
| | Physician /Medical Examiner | | 23a. Part 1. Entar the disease, or contact of the part feilure. List only immediate Cause (Finel disease or condition | | | _ | 005 Rei r the mode of dy | | | | | i | Approximate Intervei Between Onset and Deeth |
| | Balli | ner | resulting in deeth) | | Due to (or es | e consequ | enca of): | 26 | | | , | | 1044 |
| 0, | icate be executed physician and s the burial-transit | Examiner | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events | DI | Due to (or es | a consequ | | | 5 | | | 12 | ZYEMS |
| κ 68760, | E 0 6 | Medical | thet initiated events resulting in deeth) Last | a. An | Due to (or es | ė conseque | | | | | | | 1 Year |
| Box | 6 9 | | | d | | + | | | | | | | |
| P.O. | by the | Physician | Part ii. Other significant conditions | contributing to death to | out not resulting | g in the und | derlying cause gi | iven in Part I | | | tobacco use co Yee 2□ No | ontribute to | the cause of death? |
| Records, | aw requires is been sign 2 should be | Completed by | | | | | | | | | an autopsy ormed? | con | are autopsy findings blieble prior to mpletion of cause death? |
| | 0 5 % | E | | | | | | | | 10 | Yes 20 No | 10 | Yas 22 No |
| Vita | ysiclan: The | Be | 25. Wes case referred to medical examiner? | | , | | | 28. Place | of Deeth | (Check only | one) | | |
| of | 0 0 | 2 | Y Yes 2 No | Hospitei: Inpati | | Outpatient | 3LI DOA | | | | dence 6 □Ot | |) |
| lon | Affer fund | atlon: | 27. Menne of Deeth 1 Neturel 5 Pending 2 Accident Investigation | | ary Year) 281 | b. Time of Injury | 28c. Inju Wo M 1 | ryet ork?]Yes 2 □ | | 28d. Describe | how injury occu | red | |
| Division | for Attended after Seal Director: | Certification: | 3 Suicide 8 Could not determine | 28e. Piece of in | jury - At home, c. (Specify) | , ferm, stree | et, factory, offica | | 2 | 28f. Location (City or To | Street end Num wn, Stete) | ber or Rure | l Route Number, |
| (| Fundament III | edical (| 29e. Certifier (Check only one) Certifying P | hystcian: To the best miner: On the basis o and menner st | f examinetion | lge, deeth o end/or inve | occurred et the ti estigetion, in my | ime, dete en opinion, dee | d plece, a th occurre | and due to the ad et the time, | cause(s) end m dete end piece, | anner es st | eted. the ceuse(s) |
| / | with to the To the comp | Me | 29b. Signature and title of certifier | 1 | / | | 29c. Licen | se number | | | 29d. Dete signe | ad (Month, I | Dey, Year) |
| | / | | Down H. | church | de, 1 | w | 1)2 | F22 | -1 | | rebuar | 4/7 | -, 1996 |
| | 1) | | 30. Neme end eddress of person who | completed cause of c | death (item 23 | e) (Type, P | rint) | 1 0 4 | Let C | 1,1050 | MAICTO | n M | 414(AN) |
| | Sta | 1 | 31. Dete filed (Month, Day, Year) | The Project | rer's ignature | Nem | 1011/12 | Aver | ع مر | west | 7911031 | 10 200 | 21157 |
| | Registi | ar | 1 507 7 1000 | | | | | | | | | | , , |

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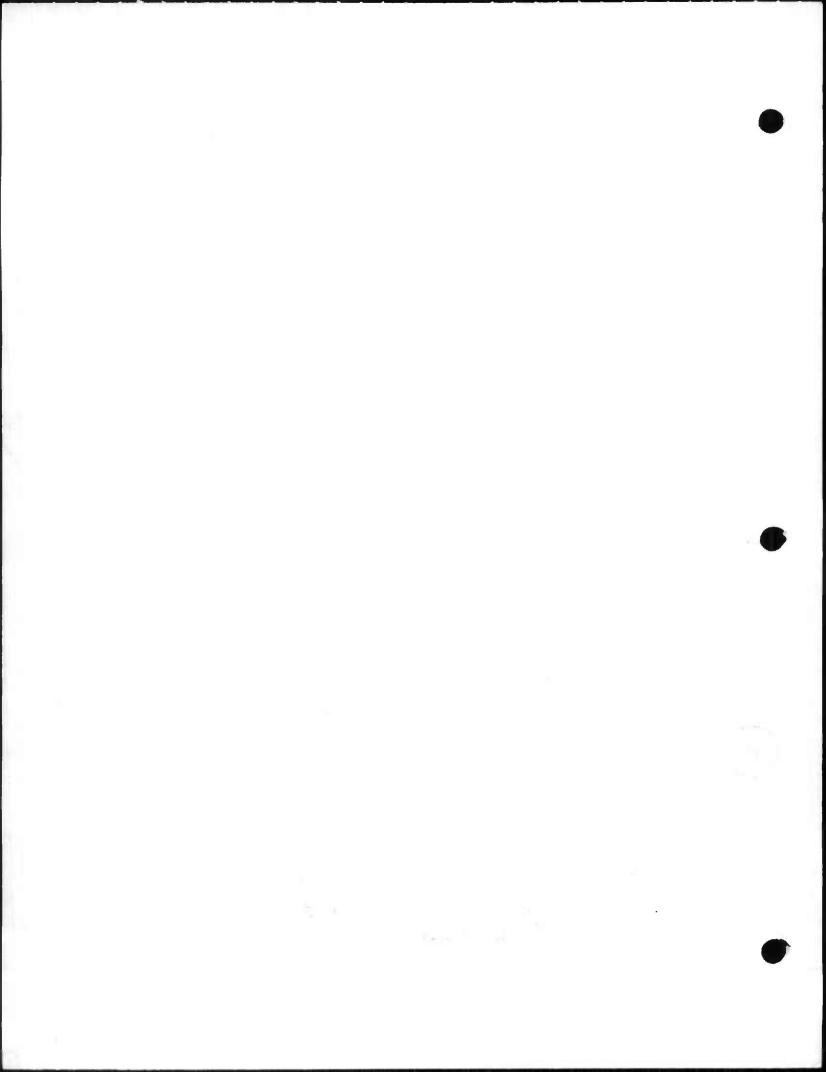
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| D.R.S | | | State of M | aryland / De <i>C</i> | partment ertificate | | | | giene 9 Reg. No. | 6 0 | 3902 |
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| Physic /Med | | Decedent's Nama (First, Middle, Last FORREST | | RNS | | | | 2. Data of De Month FEB | Day | Year 996 | 3. Tima of Death |
| Exami | | 4a. Facility Nama (If not Institution, giva 1215 WEST NORT | | RKWAY | | | City, Town, o | Location of Deat | 4c. County | of Death | |
| Funeral Director | | | x 7. Ag 7. Ag 7. Ag | a (In yrs. last birthda 88 Yrs | Months | 1 Yaar Days | If Under 24 Hr Hours Mir | | th ly, Year) 1907 | 9. Birthpl Count UNKN | aca (Stata or Foreign try) IOWN |
| Maryland H show | tor | Usual Rasidance of Dacedant 10a. Stata 10b. County Maryland Balto C | ity | 10c. City, Town or | Location | | Baltin | nore | | 16 | 0d. Insida City Limits |
| with the 3s or 28s | I Director | 10e. Street and Number | W. Nort | hern Pkwy | 10f. Zip (| Coda | 21209 |) | 10g. Citizen of USA | What Coun | iry? |
| Baltimore, Maryland 21215-0020 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Armed Forcas? 1 Yas 2 If If Yas, Giva Year or Datas: | No | 3. Was Decede If Yas, speci | | panic Origin? (Maxican, Pua Specify: | Specify Yas or No rto Rican, atc.) | 14. Rac Bla Specif | e - Amarica ck, Whita, a | atc. |
| Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours af separtment of Health and Mental Hyglene. Important: If frem 27 is marked other than "natural", or ny fully or other traumatic svent, the Medical Expansions. | Completed | 15. Decedent's Edu (Specify only highest grad Eiementary/Secondary (0-12) Unknown | ication a co <i>mplated)</i> Collega (1-4or ! | (G | cedant's Usual iva kind of work a. DO NOT use dustria | k dona du e retired) | ring most of w | orking | 16b. Kind of B Westin | | |
| /land uld be file //ental Hy rked oth | To Be C | 17. Fathar's Nama (First, Middla, Last) Thomas Willia | m Burns | | | | Mabe | | SS | | |
| and 2 sho lealth and I may le man | | 19a. Informant's Name/Ralationship (T) Theresa Harding | rpe, Print) | Naci | LUIIS Da | IIK I | JU 5. C | naries S | treet B | alto. | |
| timore L. Pages 1 tment of H tant: If ite | | 20a. Mathod of Disposition 1X Burlal 2 Cramation 3 F 4 Donation 5 Other (Specify) | | 20b. Place of Discomalary, of St. Mar | y's Cem | neter | У | 2/9/96 | Hampder | | |
| Ball permit Depart Import | | 21. Signature of Fulneral Service Ucens | a Carata | lec | 3631 F | e-Hen | ss Fune | eral Home Baltimore | . Marvl | and 2 | 21211 |
| Physician /Medical | | 23a. Pent. Enler the of hart, or completock, or heart fellule. List only of Immediate Causa (Final disease or condition | | | | | | | | - | Approximata Interval Between Onsat and Death |
| Examiner | Iner | rasulting in death) | Compli | Cleron C Due to for as a con Carell | sequence of). | itua | oltern | ~ | | | |
| Box 68760, seth certificate be executed attending physician and for use as the burial-transit | n/Medical Examiner | Sequentially list conditions, if any, leading to immediata ceusa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Lasf | 3 | Due to (or as a cons | sequence of): | | | | | | |
| P.O. nat the dd by the detached | Physician/M | Part II. Other significant conditions cor | ntributing to death b | ut not resulting in the | a undarlying ca | iusa givar | in Part I. | | tobacco use co Yes 2□No | | the cause of death? |
| Rec e law hes b | Completed by | | | | | | | perto | | ava con of c | re autopsy findings illeble prior to nplation of causa death? |
| of Vital I Physician: The | To Be Co | 25. Was casa raterred to medical axaminar? | fospital: 1 ☐ Inpatie | nf 2□ER/Outpai | tient 3 DO | Other | | eth (Check only o | | | lyas 2□No |
| Division o | Certification: | 27. Mannar of Death 1 Naturel 5 Panding 2 Accident invastigation 3 Suicida 6 Could not be | 2-6- | 1 10 - 0 | 3 M | | as 2 No | in Sr | how Injury occur Streat and Numb | | Lapsed |
| fille | al Certif | 4 Homicide dataminad 29e. Cartifiar 1 Certifying Physics | building, atc | home it | Yard | t the time | data and nice | City or Tou | vn, Steta) | Orn | Pakuny |
| 1 2 2 2 | Medical | (Check only one) 29b. Signatura and title of certiffier | nar: On the best of and mannar sta | axamination and/or | Invastigation, i | in my opir | nion, daath occ | urred at tha tima, | deta and piace, 29d. Data signe | and dua to | tha causa(s) |
| 10 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | · 8 | 94 | | 0 | .C.N | 1.E | | FEB. 7 | , 19 | 96 |
| | | 30. Nama and eddress of person who co | empleted causa of di | aath (Itam 23a) (Typ 111 Per | nn Str | eet | Balt | imore, | Maryla | and 2 | 1201 |

State Registrar 31. Date flied (Month, Pay Year) FEBI 4 1996

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| DIVISION OF THE RECORDS, P.O. BOX 68760 | DIL OR ATTENDING HYSICIAN: TH | AL DIRECTOR: After this certificate | 72 hours after death in the Stay | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
|---------------------------------------|--|--|--|--|--|--|---|---|--|-------------------------|--|
| | Carmela Bellome | 0 | | | | | 2.0 | bruary | | 7 - 10 | 2.10 |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | GE (In yrs. I | | IF UNDER 1 YEAR | | RS. 7. C | MTE OF BIRTH Month, Day, Year) | 111 | 6. BIRTH | IPLACE (State or Foreig |
| | 216-03-0761 | 1 M 2 🔀 F | 85 | YRS. | IONTHS DAYS | HOURS M | | ov. 11, | 1910 | Count | talv |
| | Se. FACILITY NAME (If not institution, give : | street end number) | | | 9b. CITY, TOWI | OR LOCATION O | | | | NTY OF D | |
| CTOR | Riverview Nursi | | Inc. | | Ess | ex | | | Ва | 1tim | ore Count |
| DIRE | Maryland Balt | imore Cou | nty | | SSEX | CATION | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | - | 10g. CIT | IZEN OF Y | WHAT COUNTRY? |
| Ä | l Eastern Blvd. | | | _ | | 21221 | | | Uni | ted | States |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 1 YES, GIVE WAR O | ES 2X | | If yes, | ECENDENT OF HIS specify Cuban, Me ES 2 1 NO S | xican, Pu | | es or No— | | E — American Indian, k, White, atc. Hy: White |
| ED | 15. DECEDENT'S EDU | | 16a. E | DECEDENT'S U | SUAL OCCUPA | TION | | 16b, KIND OF B | ISINESC/IN | HISTON | WILLE |
| ET | (Specify only highest grade Elementary/Secondary (8-12) | | | (Give kind of wo | rk done during i | | | | | | cturing |
| PL | 8th Grade | College (1-4 or 5+) | Se | eamstre | ess | | | Compar | | LITOLLO | ccuring |
| COMPL | 17. FATNER'S NAME (First, Middle, Last) | | | | | 16 MOTHER'S | NAME /E | irst, Middle, Maide | n Cumama) | | |
| - | Carmello NMN | Bellomo | | | | Mary | | ret, MIUCIE, MEICIE | n Surneme) | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | Dellomo | | OP MAILING A | DDRESS (Street | t end Number or Ri | | Number Chies T | one Chata Tie | Onde | |
| 2 | Marie F. Walter | | | | | Road, Ba | | | | | 224 |
| | 20g. METNOD OF DISPOSITION | | 20h DI 4CI | E AND DATE OF | | | | | | | |
| | 1 N Burisi 2 Cremation 3 Rem | | cemetery, c | rematory or other | r place) | | 1 | | OCATION — | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | Lake | e View | | ial Park | | | kesvi | ille, | Maryland |
| | *Kathleen | m. M. | age. | hy/ | | | | 0 1 2 2 | | | 2120 yland |
| | 23. PART I. Enter the diseases, or | complications that car | | | | | LCL 9 I | nc bart | - IIIIO L C | , | Jana |
| | IMMEDIATE CAUSE (Final | List only one cause of | n eech iir | 10. | t enter (ng n | lode of dying, | such aa | cardiac or res | piratory an | rest, | Approximata interval Betw |
| | IMMEDIATE CAUSE (Final | List only one cause of | n eech iir | 10. | t enter (ng n | lode of dying, | such aa | cardiac or res | piratory an | rest, | Approximate interval Betwoonset and D |
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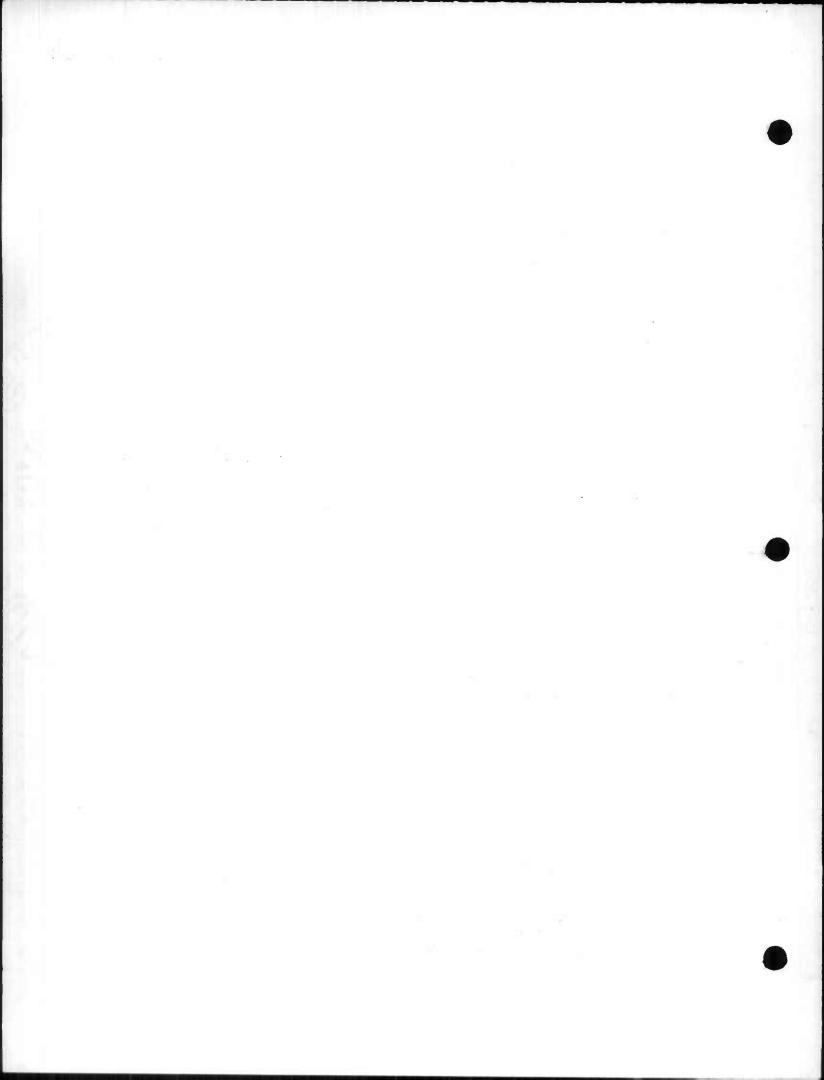


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

| DIVISION OF VITAL RECORDS, P.O. BOX 6876C TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - FOR STATE OF MARYLA REGISTRAR | ND / DEPARTMENT CERTIFICATE | | MENTAL HYGIENE REG. NO. | | |
|---------------|--|--|--|--|--|---------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | - | | 2. DATE OF DEATH | 3. | TIME OF DEATH |
| | WILLIAM D. COLL | INS | | FEBRUARY 11, | 1996 | 935 PM |
| | | yrs. lest birthday) IF UNDER : | DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) JANUARY 26, 19 | New Y | CE (State or Foreign |
| | Se. FACILITY NAME (If not institution, give street and number) | 96 <u>. CI</u> TY, | TOWN OR LOCATION OF DI | EATH 9c. | COUNTY OF DEATI | |
| DIRECTOR | Mercy Hospital | 150 | Itimore | | Salti1 | nore |
| IREC | 100. STATE 10b. COUNTY | 10c. CITY, TOWN OF | MOCE | | | LIMITS? |
| | 100. STREET AND NUMBER | Dat | 101. ZIP CODE | 10g | . CITIZEN OF WHAT | |
| FUNERAL | 105 N. JANNEY ST | | 2122 | 4 | USA | |
| BY FUI | 11. MARITAL STATUS 1 Never Merried 2 Merried 12. WAS DECEDENT EVER IN FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DAT | 2 NO II | MS DECENDENT OF HISPAI yes, specify Cuben, Mexico | | o- 14. RACE Black, Wi Specify: Whit | |
| 8 | 18. DECEDENT'S EDUCATION | 16a. DECEDENT'S USUAL OC | CUPATION | teb. KIND OF BUSINES | | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8 +) | (Give kind of work done d life. Do NOT use retired.) | | Steel | | 20 1797 |
| MP | Unknown | Factory Wor | ker | 00001 | | |
| | 17. FATHER'S NAME (First, Middle, Lest) Henry Collins | | 18. MOTHER'S NA Agnes | ME (First, Middle, Meiden Surna Unkn | | S. V |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS | (Street and Number or Rural | Route Number, City or Town, Sta | nte, Zip Code) | |
| | Margaret M. Collins 200. METHOD OF DISPOSITION 200. | PLACE AND DATE OF DISPOSI | | timore, Md. 2 | N — City or Town, | State |
| | A GARD AND A CONTRACTOR A CONTRACTOR AND | | | dens 2-14-96 | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. I | name and address of FA narles S. Ze | eiler & Son I | nc. | |
| | 23. PART I. Enter the disease, or complications that coused | the deeth. Do not enter | 1 S Conkling | g St Balto | Md. | Approximeta |
| | shock, or heart fellure. Liet only one ceuse on ee IMMEDIATE CAUSE (Finel disease or condition resulting in death) s. A S C V | | | | | Intervel Batween Onest and Death |
| | DUE TO (OR AS A | CONSEQUENCE OF): | | | | |
| TION | Sequentially list conditions, if sny, leading to immediate | CONSEQUENCE OF): | | | | |
| CA | CAUSE (Disease or Injury | CONSEDUENCE OF): | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | CONSESSENCE OF J. | | | | |
| | PART II. Other significant conditions contributing to deeth but | stant regulting in the un | deriving ceuse given in | Part I. 24s, WAS AN AUTO | OPSY 24b. WE | RE AUTOPSY FINDINGS |
| CAL | Chronic Obstructive | Pulmonari | - Disease | PERFORMED | 7 AM | MILABLE PRIOR TO MPLETION OF CAUSE |
| MEDIC | | erria 0 | | | | DEATH? |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | DEATH YES | NO UNCERTAL | N 🗆 | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 6. PLACE OF DEATH (Check of the | | | | |
| YSI | 1 YES 2 1 40 1 Inpatient 2 ER/Output | stient 3 DOA 4 Num | sing Home 8 - Residence | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 26d. DESCRIBE HOW INJUR | RY OCCURED | |
| FED BY | 2 ACCIONIN | — Al home, farm, street, fact | ory, office | 281. LOCATION (Street end N City or Town, State) | lumber or Rural Rout | e Number, |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowle | edge, death occurred at the 1 | ime, date and place, and du | e to the cause(s) end manner | as stated, | 100 |
| MO | One) 2 MEDICAL EXAMINER: On the basis of examination | and/or investigation, in my o | pinion, death occured at th | e time, date end place, end du | e to the cause(s) er | nd manner es atated. |
| BE | 296 SIGNATURE AND TITLE OF CERTIFIER | D | PO96 | MBER 29- | d. DATE SIGNED (M | Feb; 113 6 |
| 10 | 30. NAME AND ADDRESS OF BERSON WHO COMPLETED CAUSE OF DEA | | 5. Greene | St, Baltir | nou, MD | 21201 |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNA | ATURE | | | | |
| | FEB 1 4 1996 July Deweler Per | tell | | | | DHMH-18 Rev 1/89 |



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| | - | | | | Pertificate of | Dealii | | Reg. No. | | |
|--|---|--|--|--|--|--|--|---|--|--|
| Physicia /Medica | ai - | Decedent's Neme (First, Middla, Lass LESLIE As. Facility Neme (If not institution, give | Jasmine | | CA | I.I.E | 2. Date of De Month FEBRUA | Dey ARY 12 | , 1996 | Time of Death 0655AM |
| Examine uneral irector | | ST. AGNES HOSP 5. Social Security Number 6. Sr 218-45-2532 | ITAL E.R | (In yrs. last birthd | Months Day | BALTIMO ar if Undar 24 Hr | ORE CITY | Y N/. | A | (State or Foreig |
| how | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town o | r Location | | | | 10d. I | nsida City Limi |
| 28a-1 Inctified | Director | Maryland Baltimo | ore | Woodlav | ₩n. 10f. Zip Code | a | | 10g. Citizan of N | | Yes 2 🛣 N |
| 23a o | a D | 2 F Springridge | Court | | 212 | 44 | | United | States | |
| if, or items | by Funeral | 11. Marital Status 12 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedant E Armed Forces? 1 Yes 2 No. If Yas, Give Yaar or Datas: | | if Yes, specify C | of Hispanic Origin? (uban, Mexican, Pue No Specify: ECI | erto Rican, etc.) uador — El | Blac | ce - Amarican ir ck, Whita, etc. y: Hispa | |
| natur | Completed | 15. Decedent's Ed (Specify only highast grad Elementery/Secondary (0-12) | ucation da completed) College (1-4or 5- | (G | ecedent's Usual Oce ive kind of work do re. DO NOT use ret | cupation na during most of w | Salvador orking | | usinass/Industr | у |
| is marked other than raumatic evant, the M | Be | N/A 17. Fether's Neme (First, Middle, Last) | | | | 100 | ema (First, Middle, | | | |
| merk metic | 2 | Wilson Calle 19e. informent's Neme/Reletionship (7) | "voe. Print) | 19b M | leiling Address (Str | Carr eet and Number or F | nen Argue | | State 7in Cod | (e) |
| 27 is or trau | | Mr. Wilson Calle | | | | dge Court | | | | |
| ant: If Itam 27 is ury or other tra | | 20e. Method of Disposition 1 □ Burlai 2 □ Cramation 3 🔀 4 □ Donetion 5 □ Other (Specify | | cemetery, | isposition (Nama of crematory or other) | olace) | Date 2-16 | | City or Town, | |
| Important: If I any injury or once. | | 21. Stopsture of Funerel Service Licens | | | | | ral Direc | | nc. | |
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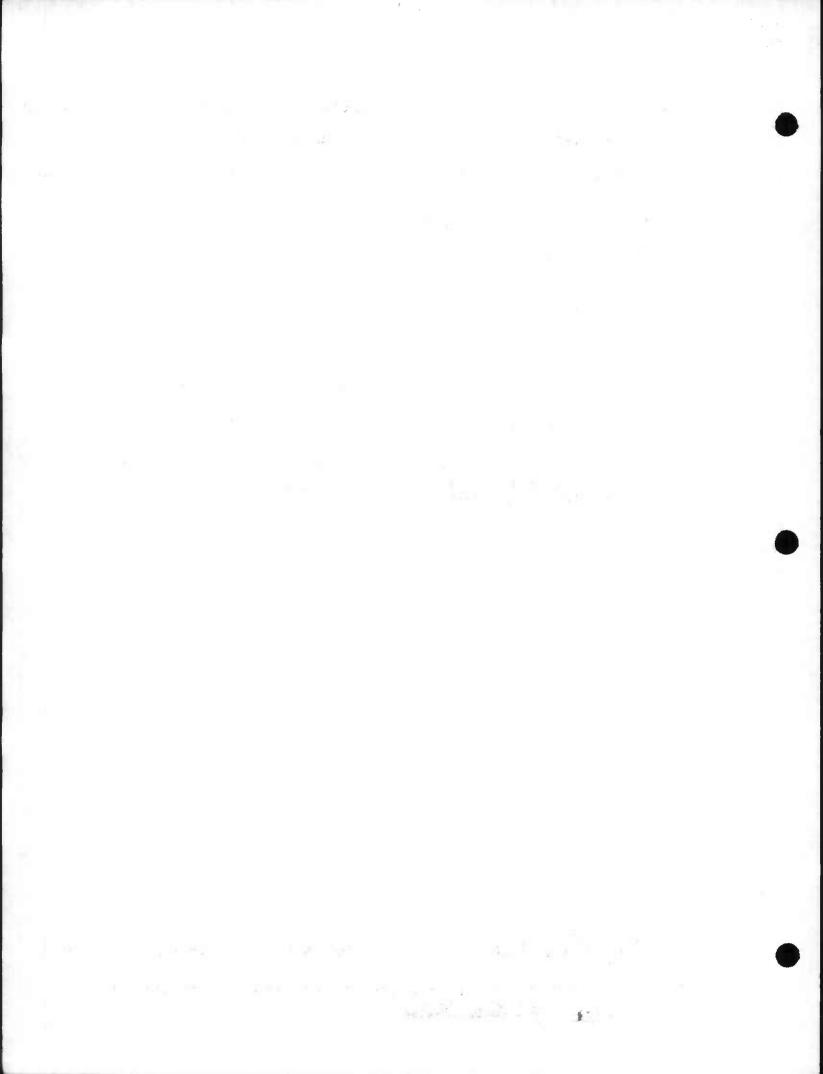
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State of Maryland / Department of Health and Mental Hygiene

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| Dhusta | ion | 1. Decedant's Name (First, Middle, L | ast) | | | | | | 2. Data of Daai Month | | Van- | 3. Tima | ot Death |
| Physici /Medi | | DOROTHY | | | | DAV | S | | FEBUAR | Y 10 | 1996 | 10: | 18 A |
| Examir | | 4a. Facility Nama (If not Institution, g | va street and number) | | | | | n, or Loc | ation of Death | | ty of Death | | |
| | | CHURCH HOSPITAL | | | | | BALTI | MORI | E | N/A | | | |
| Funeral | | Social Security Number 6. | Sex 7. Age | a (In yrs. las | | Undar 1 Ye | ar If Under 2 | 4 Hrs. | 8 Date of Birth | | 9. Birtho | olace (State | a or Foreid |
| irector | | 220-76-8048 Usual Residence of Decedant | 1□ M 2 C JF / | 47 | Yrs. | lonths Day | s Hours | Min. | Month Day | 10 48 | Nort | place (State http) Th Ca | aro1 |
| * m | | 10a. Steta 10b. County | | 10c. City, T | Town or Location | ion | | | | | t | Od. tnside | City Limit |
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| 28 | Director | 10e. Street and Number | | рать | imore | 10f. Zip Code | 0 | | | 0g. Citizan of | What Cour | ntn/2 | |
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| f item 27 in other tre | | Shirley Smith | /Sister i | in la | \$35 S€ | outh | Spring | Co | urt Ba | alto. | Md. | 2123 | 31 |
| r off | | 20a. Mathod of Disposition | | 20b. Plac | e of Disposition etary, cremato | on (Nama of | | 1 | | 20c. Location | | | |
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| in in | | 21. Signature of Funaral Sarvice Llos | peed / / | 11 | 1 22. Na | ame and Ado | rass of Facility | | | | | | - |
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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| PPTAL DR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | ERAL DIRECTOR: After this certificate has been sligned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | n 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | T: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| E HOSPITAL | CUNERAL | 3 within 72 | RTANT: 11 |
| TO T | TO TH | be file | IMPO |

| STATE | | MARYLAND / | DEPART | MENT OF I | HEALTH AND I | MENTAL | HYGIEN | E | | |
|--|--|--|--|--|--|-------------------------------------|---|---|-------------------|---|
| REGISTRAR | | CE | RTIFIC | CATE OF | DEATH | | REG. NO. | | | |
| . DECEDENT'S NAME (First, Middle, Le | | | | IIIL EST | _ | 2. DATE O | DA | | YEAR | 3. TIME OF DEATN |
| | Monroe | | | wson, | , | | Feb 1 | | | 10:10 pm |
| SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | | Day, Year) | | 8. BIRTH Count | NPLACE (State or Foreign ry) |
| 216-05-6115 | 1 M 2 □ F | 80 | YRS. | | | | 11, 19 | 15 | Ma | ryland |
| e. FACILITY NAME (If not institution, gi | | | | | OR LOCATION OF DE | | | 9c. COUN | | |
| Saint Joseph I | | er | | To | waon, Ma | ryland | | | Balti | more |
| DESIDENCE OF DECEDENT | | | 10c. CITY. | TOWN OR LOCA | TION | | | | | 10d. INSIDE CITY |
| Maryland | n/a | | | altimor | | | | | | LIMITS? |
| Oo, STREET AND NUMBER | 11, 4 | | | | 1. ZIP CODE | | | 10a CITIZ | EN OF V | WHAT COUNTRY? |
| 6524 Sanzo Roa | d | | | | 1209 | | | | SA | , , , , , , , , , , , , , , , , , , , |
| 1, MARITAL STATUS | | IT EVER IN U.S. AR | MED | | CENDENT OF NISPAN | NIC OBIGINS | (Enacida Van | | | E American Indian, |
| ☐ Never Merried 2 Merried | FORCES? 1 | YES 2 AA | 10 | II yes, sp | pecify Cuben, Mexica | n, Puerto Ri | | or No. | Blac | k, White, atc. |
| ☐ Widowed 4 ☐ Divorced | IP YES, GIVE Y | MAR OR OATES | | 1 L YES | S 2 X NO Specify | y : | | - 1 | Spec | Black |
| 15. DECEDENT'S I | | 16a. DE | CEDENT'S U | SUAL OCCUPATI | ON | 16b. I | KIND OF BUS | INESS/INDU | JSTRY | DIGCK |
| (Specify only highest g | rade completed) College (1-4 or 5 | (Gi | ive kind of wo Do NOT use | ork done during m retired.) | ost of working | 12.000 | | | 100 | |
| 12th Grade | Conlege (1-4 of 3 | " | Post | al Work | er | U. | S. Po | sta1 | Ser | vice |
| 7. FATNER'S NAME (First, Middle, Last) | | | | | 18. MOTNER'S NA | - | | | | |
| Robert Monroe | Dawson, Sr | | | | Rosel: | ' ' | | , | | |
| Do. INFORMANT'S NAME (Type/Print) | Da. 100117 D2 | | b. MAILING | ADDRESS (Street | and Number or Rural I | | | n State Zin i | Codel | |
| Jocelyn P. Tra | vnham | | | | Court | | | | | re, MD 21209 |
| 00. METHOD OF DISPOSITION | | | | F DISPOSITION /N | - | DATE | The second second | CATION — C | | |
| ☐ Burlet 2 ☐ Cremetton 3 ☐ F ☐ Donetton 5 ☐ Other (Specify) | temoval from State | cemetery, cre Metro | metory or oth | ner place) | | | | | | , Maryland |
| 1. SIGNATURE OF FUNERAL SERVICE | LICENSEE | Mecro | Crem | | NO ADDRESS OF FA | CUTY No | ttor | CITEAL | 1116 | Homes, Inc. |
| May 7 | 1 0 00 | | | 2501 | Gwynns F | alls | Parkw | av | aI. | Homes, Inc. |
| Juny (| Rolling | | | Balti | Gwynns Famore, Ma | rulan | d 21 | 24.0 | | |
| 23. PART I. Enter the diseases, | or complications the | al caused the de | | | | TATOIL | ~ ZI | 216 | | |
| shock, or heart fallu | | | ath. Do no | | | | | | est, | Approximate |
| manuel HALE CALISE (Final | ciet offiny offia Ca. | use on sach lina | ath. Do no | | | | | | et, | Interval Between |
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| Sequentially list conditions, farty, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition | a. DUE TO b. ARTE OUE TO c. DUE TO d. titions contributing to LITUS NTRIBUTE TO CA L HOSBITAL: 1 JARTION 2 280. PLACE (Month, I) be did 280. PLACE (Duilding do NYSICIAN: To the best of the contribution of | DOOR AS A CONSECTION OF INJURY — At ho, ste, (Specify) | DUENCE OF) EPOTIC DUENCE OF) COURNEE OF) | of enter the months of the control o | OVASCULA To Cause given in UNCERTAIL UNCE | Part I. B Other 28d. DCSC City o | EASE 24e. WAS AN PERFOR 1 VES 2 (Specify) CRIBE NOW I | AUTOPSY IMEO? | 24k | interval Between Onset and Dast 3 DAYS YEARS VEARS WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 YES 2 |
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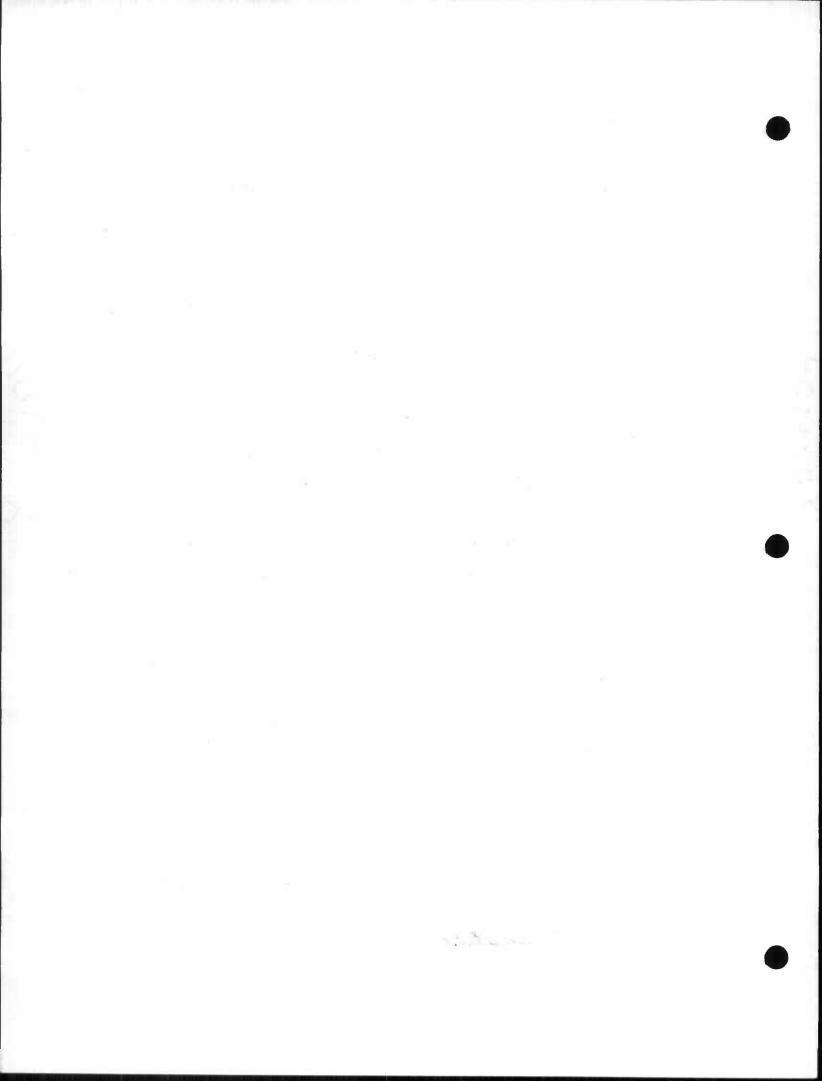


DR. MEHTA P. JOGINDER M.D., 7620 YORK ROAD, TOWSON, MD. 21204

31. OATE FILED (Month, Day, Year)
FEB 1 4 1996

July Muslim Road

A 1996



Items17,19a 2-20-96 FilmG732 W.H.Per F/H

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 6 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Vaar **Physician** DAILEY MIICHAEL 1525 PM FEBRUARY 12 1996 /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMIORE If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months 12 M 2□F 212-50-2964 Yrs 48 Director July 26, 1947 Maryland Usuai Rasidance of Dacedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar nata be notified at Maryland Baltimore Woodlawn 1 Yes 20 No Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 2031 Kennicott Road 21244 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. filed within 72 hours after Hygiene. 1 ☐ Yas 2 ② No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Salesman Automobile permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othin any linury or other traumatic event obtes. 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumeme) Be Bernard Childs Daily Dailey 2 19a. Informant's Name/Ralationship Ella Dailey 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Ella Daily 2031 Kennicott Road Woodlawn, Maryland 21244 (Mother) Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Metro Crematory Inc. Feb. 14,1996 Catonsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensea 22. Nama and Address of Facility Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland 21228 usseuce VI Part1. Entar tha diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one deuse on each line. Approximata Interval Between Onsat and Death Physician Immediata Causa (Final diseasa or condition rasulting In daeth) /Medical & ATHEROSCLEROTIC CARDIOVASCULAR DISEASE >5 YEARS Examiner Due to (or as a consequence of): Examiner DIABETS 75 YEARS The lew requires that the death certificate be executed attending physician and for use as the buriel-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): the Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? o signed by 1 Yes 2 No 3 Probably 4 ℃ Inknown ۵. FAILURE RENAL Division of Vital Records, by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deen DEPRESSION certificate has 1 Yas 2 No 1□ Yas 2₽No ANEMIA or Attending Physician: after death. 25. Was casa referred to madical examinar? Be 28. Place of Deeth (Check only one) Hospital: 1 Sinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 10 1 ☐ Yes 2 ☐ No this funeral 28b. Tima of Injury 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Director: After 5 Panding Invastigation 1 Neturel 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 ☐ Sulcida Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 24 hours a Funeral D edical 29a. Certifiar 1 Certifying Physician: To tha best of my knowladge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) K.S. RAO. M.D FEBRUARY 12 1996 D 43462

30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) FEB 1 4 1996



S. RAO.M.D., NORTHWEST

NAME OF THE PARTY

96-662-510 PART I, 27, PER MED State of Maryland / Department of Health and Mental Hygiene 96 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. FILM 6-732 2/29/96 t t State of Maryla film 9732 item#4 2/14/96 ag per FH Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month Day Physician FEB. 10, 1996 MICHAEL ERVIN 14:43 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 2004 N. CHARLES ST BALTIMORE n/a # Under 1 Year Months | Days 8. Data of Birth (Month, Day, Yaar) NOV . 26, 1933 Undar 24 Hrs. Hours Min. 9. Birthpiace (State or Foreign County)
BALTIMORE, MD 5. Social Security Number 7. Aga (fn yrs. iast birthday) 6. Sex **Funeral** 212-26-6173 1 XXX 2 F Yrs **Director** 62 Usual Rasidance of Decedant the Maryland 10d. Insida City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at BALTIMORE 1 Was 2 No MD n/a Director 10e. Street and Number 10f. Zip Code 6 21218 238 2004 CHARLES S T. death Funeral 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 ∑No If Yas, Giva Year or Datas: items 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - American indien, Bieck, Whita, atc. 11. Maritai Status Pagas 1 and 2 should be filed within 72 hours after or sent of Haalth and Mantal Hygiana. nt: If Item 27 is marked other than "natural", or Iter 1 Never Merriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) LABORER unemployed 12 th Department of Health and Mantal Hygis Important: If item 27 is marked other any injury or other traumatic event, to once. 18. Mothar's Nama (First, Middla, Maldan Sumeme) 17. Fathar's Nama (First, Middla, Last) **EQULEAR** SR. MOBI FY ERVIN ROBERT 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Neme/Raiationship (Type, Print) AE., BALTIMORE, MD ERVIN ANDREW 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20a. Method of Disposition Data 20c. Location - City or Town, Stata N Buriai 2 ☐ Cramation 3 ☐ Removei from Stata 2-15 MEMORIAL PARK RANDALLSTOWN, MD KING 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility WM.C . MARCH FH.-1101 E. NORTH Part1. Error the disease, or complications the shock, or haert failura. List only one cause of beused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximete Intarval Batwean Onset end Death **Physician** /Medical Immediate Causa (Final **ASTHMA** diseese or condition rasulting in death) Examine Dua to (or as a consequence of): Physician/Medical Examiner physician and the buriel-transit The law requires that the death cartificate be executed Saquantially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Dua to (or es e consequança of) 0 P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown should be det Records, þ 24b. Were autopsy findings evelleble prior to Completed 24a. Was an autopsy parformed? completion of cause of death? paga 2 NE Yes NEYas 20 No 2 No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Polrector: After this certifica completally filled in by the tuneral director, s 25. Was casa raferred to medical axaminar? Be 26. Piace of Deeth (Chack only one) Hospital: Other: $_{4\,\square\,\text{Nursing Homa}}$ 5 \square Rasidanca 6 XIOther (Specify) VACANTedical Certification: To XXYas 2□ No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 KNaturai 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accidant 3 Suicide 6 Could not be datamined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, daeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and menner statad. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) FEB.11,1996 OCME

Registrar

State

31. Data filed (Month, Day, Year) FEB 1 4 1996

MARIANOS

30. Nama and addrass of person who compiated causa of death (Itam 23a) (Type, Print)

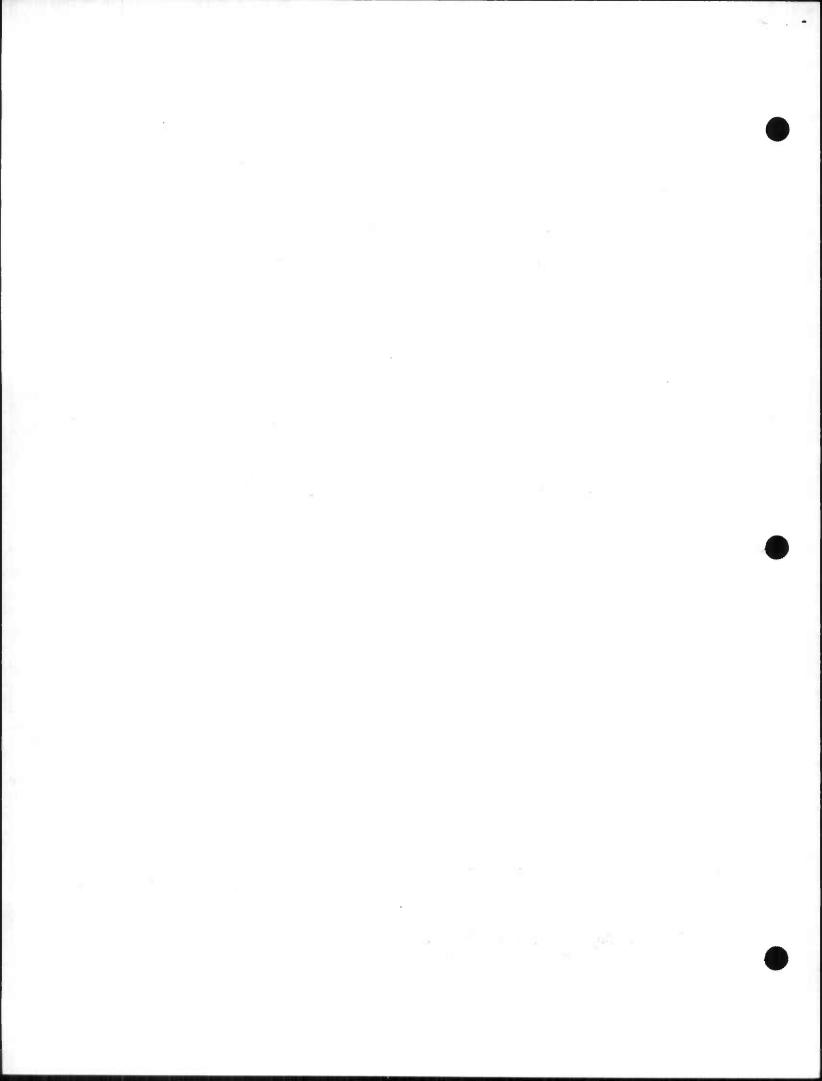
32 Ragistrar's Signatura

111 Penn Street, Baltimore, Maryland 21201

DHMH-16 Rev 1/89

| ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | RAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|---|
| TO THE HOSPITAL OR ATTENDING | IL OIRECT | be filed within 72 hours after death | MPORTANT: If item 28 is ma |

| | 1 - STATE STATE REGISTRAR | | | F DEATH | MENTAL HYGIEN REG. NO | | | | | | |
|---------------|--|---|--|---------------------|--|--|--|--|--|--|--|
| | 1, DECEDENT'S NAME (First, Middle, Lest) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | Helen Marie Esender | | | | February 9 | , 1996 [^] | 4:25 p. m | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. | AGE (In yrs. last birthday) | IF UNDER 1 YEA | | 7. DATE OF BIRTH (Month, Day, Year) | IRTHPLACE (State or Foreign ountry) | | | | | |
| | 214-01-1422 1 D M 2 💢 F | 89 YRS. | MONTHS DAY | B HOURS MIN. | March 31, | | Maryland | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOW | N OR LOCATION OF D | | 9c. COUNTY O | | | | | |
| 8 | Holly Hill Manor | | | Towson | | Balt | timore | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 100 00 | Y, TOWN OR LO | 2471041 | | | Last mains arm | | | | |
| E | | ioc. Cr | Parky | | | | 10d. INSIDE CITY LIMITS? | | | | |
| | Maryland Baltimore | | raik | 10f, ZIP CODE | | 100 CITIZEN | 1 YES 2 X NO OF WHAT COUNTRY? | | | | |
| RA | 2520 Hillcrest Avenue | | | 21234 | | | | | | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT E | VER IN U.S. ARMED | 13. WAS | | NIC ORIGIN? (Specify Yes | | S.A. RACE — American Indian, | | | | |
| BY FL | 1 Never Married 2 Married FORCES? 1 IF YES, GIVE WAR | YES 2 X NO | If yea | | an, Puerlo Rican, atc.) | | Black, White, etc. Specify: White | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S | USUAL OCCUP | ATION | 16b. KIND OF BU | SINESS/INDUSTF | 4A | | | | |
| ᇤ | Elementary/Secondary (0-12) College (1-4 or 5 +) | life. Do NOT | work done during ise retired.) | most or working | | | | | | | |
| AP. | 8 | 2nd Clas | ss Elec | trician | Ele | ectrica | 1 | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | 18, MOTHER'S NA | AME (First, Middle, Malden | Surname) | | | | | |
| BE | George R. Johnson | | | Li | llian B. G | ilbert | | | | | |
| 10 | 19a, INFORMANT'S NAME (Type/Print) | | | | Route Number, City or Tow | | | | | | |
| | Ruth E. Filbey | | | | | | yland 21234 | | | | |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State | 20b. PLACE AND DATE cemetery, crematory of LOUGON P | OF DISPOSITION other place! | (Nama of | DATE 20c. LO | CATION — City of | The state of the s | | | | |
| | 4 Donation 5 Other (Specify) | Loudon P | 22 NAMI | AND ADDRESS OF F | O | <u>Raitimo</u> | re, Maryland | | | | |
| | Leonard J. Ruck, Inc. 21214 5305 Harford Road Baltimore, Maryland | | | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that c | eused the death. Do | not enter the | mode of dylng, eu | ch ee cerdiec or reep | iratory erreet, | Approximate | | | | |
| | ahock, Dr heart failure. List Dnly Dna cause | on aach lina. | | | | | Interval Batwean Onset and Daath | | | | |
| | disease or condition | | | | | | | | | | |
| | DUE TO (OI | AS A CONSEQUENCE | OF): | | | | 2 years | | | | |
| Z | Sequentially list conditions, If any, leading to immediate | lentii Carl | OVESCH | le Visea. | <i>-</i> | | | | | | |
| H | If any, laading to broadlate | R AS A CONSEQUENCE (| PF): | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | | | | | | | | | | |
| | thet initiated events / DPE TO (Of resulting in death) LAST | , AS A CONSCOURNE (| <i>,</i> , , , , , , , , , , , , , , , , , , | | | | | | | | |
| Ü | d | | | | <u>_</u> | | | | | | |
| CAL | PART II. Other significant conditions contributing to de | ath but not resulting | in the underl | ying cause givan ir | Part 1. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | |
| | | | | | 1 TYES : | | COMPLETION OF CAUSE OF DEATH? | | | | |
| MED | | | | | | | 1 - YES 2 NO | | | | |
| ż | DID TOBACCO USE CONTRIBUTE TO CAUS | SE OF DEATH Y | es 🗆 no | UNCERTA | IN 🗆 | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 28. PLACE OF DE | | ne) | | | | | | | |
| YSI | 1 YES 2 NO 1 Inpatient 2 E | R/Outpatient 3 DOA | OTHER: | iome 5 🗆 Reeldence | 8 Other (Specify) | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 28a. DATE OF IN. (Month, Day. 1 Natural 5 Pending | JURY 28b. TII | JURY | INJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCCURE | D | | | | |
| В | 2 Accident Investigation | | | YES 2 NO | | | | | | | |
| | building, etc | NJURY — At home, term, :. (Specify) | atreet, fectory, o | office | 281. LOCATION (Street City or Town, State | and Number or Ru) | ural Route Number, | | | | |
| COMPLETED | | 4 Nomicide determined | | | | | | | | | |
| P. | 29a. CERTIFIER (Check only check on the check of th | | | | | | | | | | |
| ő | one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER RAYMOND W. WILSON MS 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | |
| TO B | 11 W W Long | | | 104/4 | 1/6 | tes | 12,1996 | | | | |
| F | 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE | OF DEATH (ITEM 27) (Typ | e, Print) | (1) | N Harr | 0 11 | MD 21204 | | | | |
| | | | 62 N. | Charler o | 1. 416 | Dr 171more | י ואין צו ציט | | | | |
| | FEB 1 4 1996 Julia Savidson | Aandalla. | | | | | | | | | |



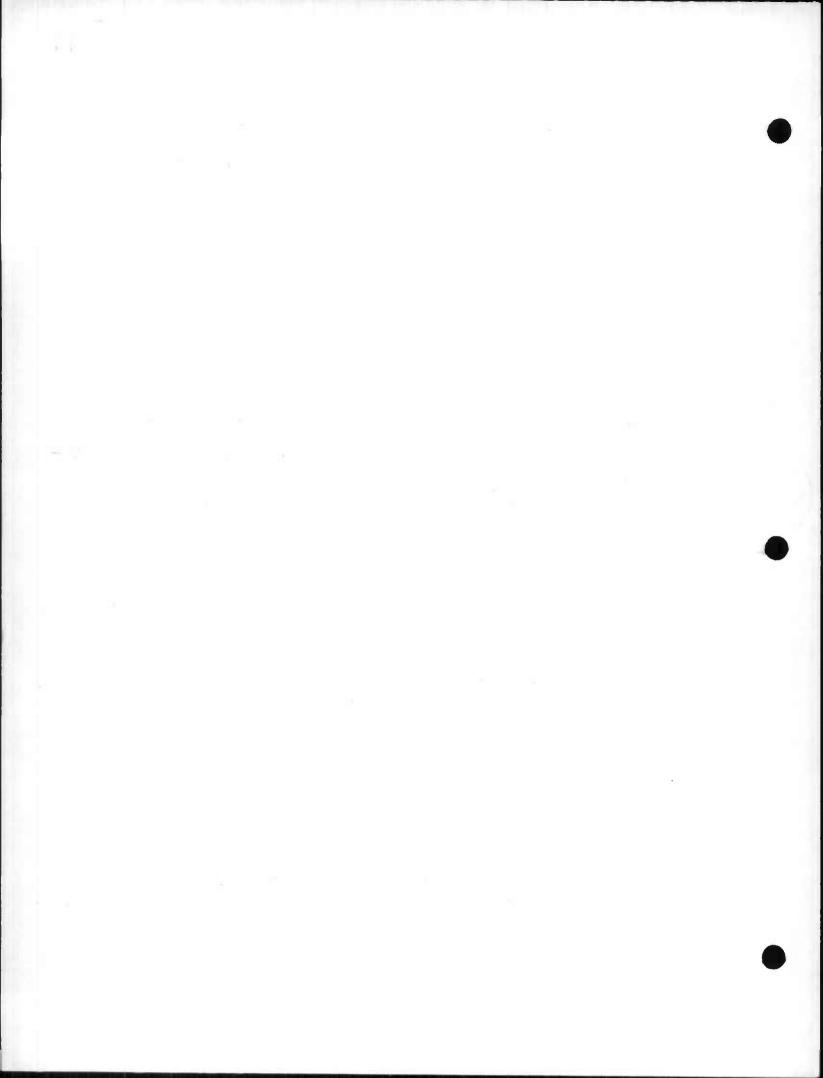
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. | INDUSTANT: If Item 28 is marked on them 23 shows any Injury or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|--|
| | | | |

| SUCHE FOUNDER S. BECOMMENT NAME (PT AS A PORT OF DESCRIPTION OF DESCRIPTION OF BURNET) S. BECOMMENT OF BURNETS PRAME (PT AS A PORT OF BURNET) S. BECOMMENT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS) S. BECOMMENT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS) S. BECOMMENT OF BURNETS PRAME (PT AS A PORT OF BURNETS PRAME (PT AS A PORT OF BURNETS) S. BECOMMENT OF BURNETS PRAME (PT AS A PORT OF BURNETS) S. BECOMMENT PRAME (PT A | ME OF DEATH | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|--|
| TREBIDIENCE OF DECEDERY THE BIDDENCE OF DEC | 1120 | | | | | | | | | |
| 8. POCITY RABE (If not simplifice give sines and running) 8. COUNTY OF DEATH RESIDENCE OF DECERBENT 8. STATE 10. COUNTY OF DATH 10. STATE | (State or Foreign | | | | | | | | | |
| TOW STREET AND NUMBER 1 | / \ | | | | | | | | | |
| TOWN STREET AND HUMBER 10. STREET AND HUMBER 100. ZIP CODE 100. ZIP COD | | | | | | | | | | |
| Do. STREET AND NUMBER 14 | INSIDE CITY LIMITS? YES 2 NO | | | | | | | | | |
| Specify Spec | COUNTRY? | | | | | | | | | |
| Specify Spec | | | | | | | | | | |
| BE SECRETIFY SEQUENTION (See an ALL OCCUPATION) (See Sequentially list conditions and failure. List only one cause on each line. PART II. Other significant conditions contributing to death but not resulting in death) 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part (Ora As a Consequence of): 23. Mas Cause (Final diseases, or complications that ceused tha death.) Do not enter the mode of dying, such as cardiac or reapiratory arrest, and it may, leading to immediate cause. Enter INDERLING (Biolesses or Injury that intilated events resulting in death) 24. Mas Cause (Couse) 25. Mas Cause (Couse) 26. Detail of work flow of many flowing house of variety flowing house of the couse of the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, and cause. Enter INDERLING (Biolesses or Injury that intilated events resulting in death) 26. Detail of the conditions and the couse of the | nerican Indian, ia, etc. | | | | | | | | | |
| Elementary Re-condary (0-12) College (1-4 or 5 +) Beyon College (1-4 or 5 or 6 or 6 or 6 or 6 or 6 or 6 or 6 | slack | | | | | | | | | |
| TOWN AS TOWN A | | | | | | | | | | |
| THE INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. PLACE AND DATE STATE OF DISPOSITION (Name of Complete) and State of Date (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Complete) and State of Date (Specify) 21. SIGNATURE OF FINERAL SERVICE LICENSEE 21. SIGNATURE OF FINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY AND CONFIDENTIAL SERVICE LICENSEE 23. PART II. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each lina. DUE TO (OR AS A CONSEQUENCE OF): 25. WAS CAUSE REFERENCE TO MECICAL EXAMINERY: 1 OTHERS: 1 OTHERS: 1 OTHERS: 26. LICATION (Street and Number or Burll Struke of Park Number or Burll S | 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) | | | | | | | | | |
| 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City or Town, Streen Date Chemation Date 20c. LOCATION - City or Town, Streen Date Chemation Date 20c. LOCATION - City or Town, Streen Date 20c. LOCATION - City or Town, Streen Date 20c. LOCATION - City or Town, Streen Date Date 20c. LOCATION - City or Town, Streen Date D | 19a, INFORMANT'S NAME (Type/Print) 19b. MAILINO AGORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 12. NAME AND ADDRESS OF FACILITY 17. OR 1. OR | 20s, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of DATE 20c, LOCATION — City or Town, State | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition resulting in death) Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JAMES A. MORTON FIH 23. NAME AND ADDRESS OF FACILITY JAMES A. MORTON FIH | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inflitated events resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE | Approximate | | | | | | | | | |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR A | Interval Batwee Onset and Dasi | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that infiliated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CON | YEARS | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. REVAL PAIL UNE PRACTURE. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 MENO 1 YES 2 M | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Compared | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Compared | | | | | | | | | | |
| 2 Accident Investigation 28. PLACE DE INJURY — At home farm street factory office 281 LOCATION (Street and Number or Rural Pouts N | E AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? | | | | | | | | | |
| 2 Accident investigation 28s. PLACE OF INJURY — At home farm street factory office 28s. LOCATION (Street and Number or Rural Pouts N | | | | | | | | | | |
| 2 Accident Investigation 2. Accident 2. Ac | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| 2 Accident Investigation 28s. PLACE OF INJUSY — At home farm street factory office 2st LOCATION (Street and Number or Rural Pouts N | | | | | | | | | | |
| 288. PLACE OF INJURY — At home farm street factory office 1 281 LOCATION (Street and Number of Rural Houte N | | | | | | | | | | |
| 29s. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | | | | | | | | | | |
| (Check only one) 2 | Number, | | | | | | | | | |
| 296. SIONATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. D 298. | | | | | | | | | | |

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DHMH-16 Rev 1/89

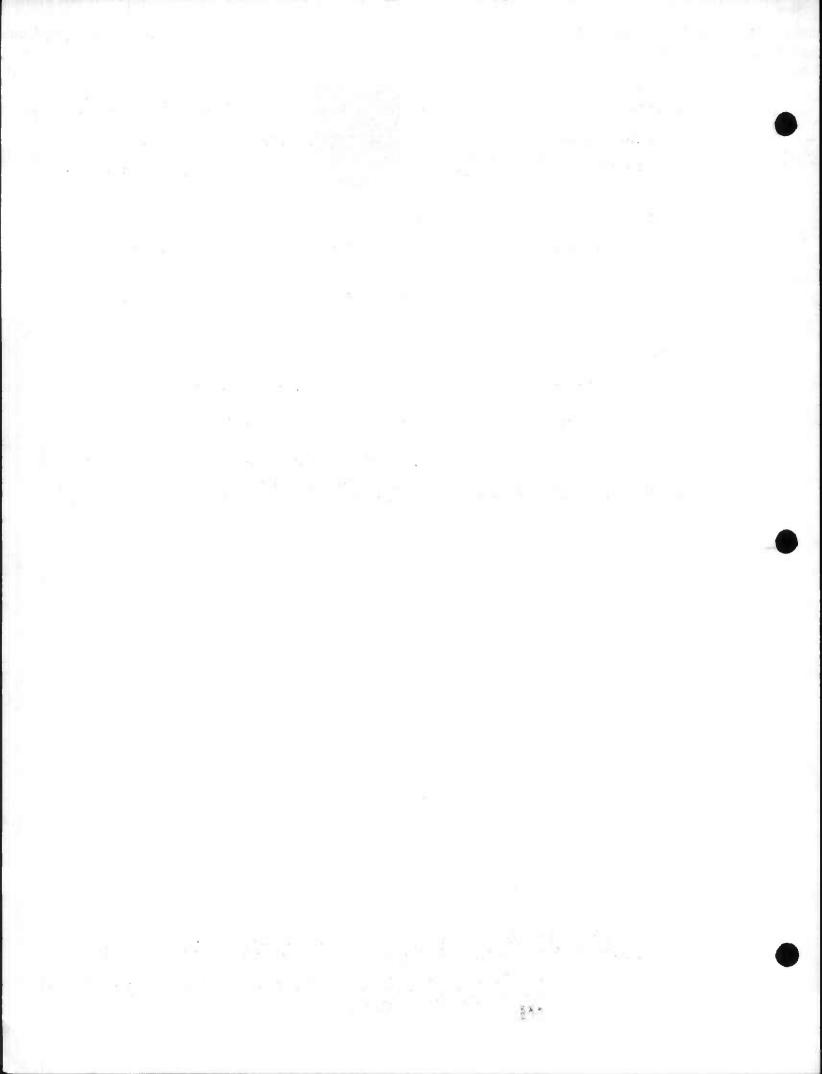
CHUNCH HOSPIAL, BALP MO2123,



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 0.39 ± 2

State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Ce | rtificate of | Death | F | eg. No. | | | | | | |
|----------------|---|------------------|---|---|---|---|---|---|--|----------------------------------|----------------------------|--|-------|--|--------|--|
| Г | St | | 1. Decedent's Neme (First, Middle, Li | nst) | | | | | 2. Date of Dee Month | | Vane | 3. Time of Death | | | | |
| | Physic /Medi | | FANNIE FRAZIER | | | | | | | ry 10, | 1996 | 9:45 pm | | | | |
| | Exami | | 4e. Facility Neme (If not Institution, gi | |) | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Deeth | | | | | |
| | | | 5012 The Alameda | | | | | Baltimo | | N/A | 1 | | | | | |
| | Funeral Director | | 220-20-9376 | Sex 7. A 1 □ M 2 XF | ge (In yrs. last b | rthdey) Yrs. | If Under 1 Year Months Deys | | 8. Date of Birth (Month, Day FEB 2 | 5,1911 | 9. Birthpl Count V11 | lace (State or Foreign try). 'Ginia | | | | |
| | pud * | | Usual Residence of Decedent 10e. Stete 10b. County | | 10c. City, Tov | m or Lo | ocation | | | | 44 | Od Incide Ohr Limite | | | | |
| | fanyle sho | 5 | Maryland N/A | | Balt | | | | | | 10 | 0d. Inside City Limits 1 ☑ Yes 2 ☐ No | | | | |
| | the N | ect | 10e. Street and Number | | Dare. | LINOL | 10f. Zlp Code | | | Og. Citizen of \ | Afhat Caus | ** | | | | |
| | ath with 23a or | Funeral Director | 5012 The Alameda | | | | | 239 | | U.S. | | шуг | | | | |
| 020 | 72 hours efter death with the Maryland "naturel", or frems 23a or 28a-f show edical Examiner must be notified at | by | 11. Merital Status 1 □ Never Married 2 □ Merried 3 ☒ Widowed 4 □ Divorced | 12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates | ? (No | if Yes, specify Cuban, Mexican, Puèrto Rican, etc.) | | | ck, White, e | etc. | | | | | | |
| 5-0 | 72 hc | etec | 15. Decedent's E (Specify only highest gr | ducation ade completed) | 168 | . Dece | dent's Usuei Occup | petion during most of work | ina | 16b. Kind of B | usinass/ind | lustry | | | | |
| 21215-0020 | within ene. then | Completed | Elementery/Secondery (0-12) | College (1-4or | 5+) | LAI | DO NOT use retire BORER | during most of work od) | 9 | vai. | tr | trades | | | | |
| | Hyg Hyg ent, | BeC | 17. Fether's Name (First, Middle, Las. | ") | | | | 18. Mother's Nem | eme (First, Middle, Meidan Sumeme) | | | | | | | |
| lan | lid be ked in | To B | Charlie W. Brown | | | | | Rebecca | E. Turn | er | | | | | | |
| Maryland | shou and N | - | 19e. Informant's Neme/Reletionship | (Type, Print) | 19 | b. Meilir | ng Address (Straa | t and Number or Rui | al Route Numbe | , City or Town, | State, Zip | Code) | | | | |
| | alth alth 27 ls | | Beulah Turner | | | Ρ.0 | . BOX 35 | 55, cour | tland, VA | 2383 | 37 | | | | | |
| Baltimore, | permit. Peges 1 end 2 should be filed within 72 ho Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natur eny liqury or other traumatic event, the Medical DRIES. | | 20e. Method of Disposition 1 | Removei from Stet | comete | ry, crer | psition (Neme of metory or other ple HAND (| CEMETERY | Dete | 20c. Location - | | wn, Stete VIRGINIA | | | | |
| İ | artme ortan | | 21. Signeture of Funerel Service Lice | | LUCEL | the second | | | 2-10 | COUNTER | 1110, | VIKGINIA | | | | |
| ä | Depariment important | | (Jelpin | Kakary | EXXI | | | eral Home orth Aven | ue, Balt | imore, | MD 2 | 1202 | | | | |
| | | | 23a. Part. Enter the diseese, or con shock, or heart feilura. List only | pilcations thet cause on each | d tha death. Do | | | | | | | Approximate Intarvai Batween | | | | |
| | Physician | | | | | | | | ٨. | | | Onset and Death | | | | |
| | /Medical Examiner | Н | Immediate Ceuse (Finel disease or condition resulting In deeth) | · M | 40000 | lia | & Tudge | retion | - Hurl | wthen | ug | Minules | | | | |
| П | | 7 | resulting in Geeting | ^ | Dua to (or as a | consec | quenca of): | | | | | | | | | |
| | pet list | ulu | | p | rona | ru | well | ery | Disco | 12 | | | | | | |
| _6 | iceta be executed physician and s the buriel-transit | Examiner | Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disaase or Injury | Dua to (or as a | as a consequence of): | | | | | | | | | | | |
| 68760, | slciar buni | | Cause. Enter Underlying Ceuse (Disaase or Injury that Initiated events | | | | | | | | - | | | | | |
| 687 | ing phy as the | Medicai | resulting in deeth) Last | | Due to (or es e | conseq | juence of): | | | | | | | | | |
| Box | anding use s | | | d | | | | | | A | | | | | | |
| | death ce e attendii d for use | cla | Pert il. Other significant conditions of | contribution to death | but not resulting | n the u | nderfving cause di | ven in Part I | 23h Did to | phacco use co | ntribute to | the cause of death? | | | | |
| P.0 | as that the death igned by the atte be detached for | / Physician/ | | | | | Multix | ole n | lyelo | WE | ≥\ | | 1 U Y | | 3 Prob | |
| Vital Records, | aw requir | Completed by | | | () | | | | 24a. Was e perfor | | eve | ara autopsy findings bileble prior to impletion of cause death? | | | | |
| E | 0 - 5 | mo: | | | | | | | 1 □ Y | 98 2 No | 10 | Yes 2□ No | | | | |
| ita | ysician: The is certificate director, pag | Be (| 25. Wes casa referred to medical exeminer? | | | | | 26. Plece of Deel | h (Check only or | 10) | | | | | | |
| of V | 5 00 | ဥ | 1 Yes 2 No | Hospitel: 1 Inpat | ient 2 ER/O | utpatier | nt 3 DOA | her: 4 Nursing Ho | ome 5 Resid | ence 6 🗆 Oth | er (Specify | ') | | | | |
| ono | 0 0 0 | ino | 27. Manner of Deeth 1 DNatural 5 □ Pending | 28e. Dete of In (Month, D | ury 28b. | Time of Injury | f 28c. Inju Wo | ry et rk? | 28d. Describe h | ow Injury occur | red | | | | | |
| Sio | erith. or: Aft the fur | catl | 2 Accident Invastigation | | | | M 1□ | Yes 2 No | | | | | | | | |
| É | Direct in by | Certification: | 4 Homicide determined | 289. Piece of in | ijury - At home, fa tc. <i>(Specify)</i> | arm, str | eet, fectory, offica | | 28f. Location (S City or Tow | | er or Rural | i Route Number, | | | | |
| 9 | Man In Personal | | | | | | | | | | | | | | | |
| • | H F F | edical | 29a. Certifier (Check only one) Cartifying Pt 2 Medical Exam | nyalcien: To the best niner: On the basis end menner s | of axamination er | a, daath nd/or inv | n occurred at the ti- vestigetion, in my o | me, dete end piece, opinion, daath occur | and dua to tha c red et the time, d | ausa(s) and ma ate end place, | and dua to | ated. tha causa(s) | | | | |
| | vithin 2 To the comple | M | 29b. Signetura end titla el certifier | 1 51 0 |) ^ | | 29c. Licens | se number | 2 | 9d. Dete signe | d (Month, L | Dey, Yaer) | | | | |
| | - | | > (merlon | 1 Naco | 211 | W |) | 11500 | 160 | tola 13 | 3 19 | 96 | | | | |
| | 5 | | 30. Neme and eddress of parson the | corporated cause of | eath (Item 23a) | (Тура, | Print) | 1113 | 0. | 0 | 0- | 00 | | | | |
| | | | Clubros 31. Dete filed (Month, Day, Year) | delt | WD 5 | 60 | 1 Lock | 1 towar | 1 Blu | de, | Re | Limera | | | | |
| | Sta Registr | | FEB 1 | 1996 Negis | the Signalare | 301- | Mandall. | : | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene . 'item 26 film g732 2/14/96 ag per HOSP. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month 13:55 p.m. Frances Elizabeth Fee February 10, 1996 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard County 5. Social Sacurity Number Funeral 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) year) 5. 1914 1□M 2☑F Yrs. 81 Director 579-03-8999 Pennsylvania Usual Rasidanca of Decedant the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 28a-f show the Medical Examiner must be notified at Maryland Howard Columbia 1 Yas 20 No Director 10e. Straaf and Number 10f. Zip Coda 10g. Citizan of What Country? ծ 238 6150 Foreland Garth 21045 U.S.A. death Funeral Hems: 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. filled within 72 hours after 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 "natural", or if Yas, Giva Yaar or Datas: 1 Yas 2X No Specify Specify: White þ 3 → Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic evant, the Manages. Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Hame 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be Frank Chiodo Unknown 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Carmen Fee (Son) 10145 Green Clover Drive Ellicott City, Maryland 21042 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Crestlawn Cemetery February 13, 1996 Marriottsville, Maryland 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Leroy M. & Russell C. Witzke Funeral Homes Witke In. 1630 Edmondson Avenue Catonsville, Maryland 21228 Maig 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata intarvai Between Onsat and Death **Physician** immediate Causa (Final disaasa or condition rasulting in daath) /Medical Acute Myocardial Infarction 1 hour Examiner Dua to (or as a consequance of): Examiner Atherosclerotic Cardiovascular Disease 10 years The law requires that the death certificate be executed bunial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of): physician s the buna P.O. Box 68760, Physician/Medicai Dua to (or as a consaquance of). ate has been signed by the a page 2 should be detached Part Ii. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Severe Emphysema with hypoxia requiring constant 02 of Vital Records. by Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Recurrent supraventricular arrhythmias certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: director, Be 25. Was casa rafarred to medical 26. Piaca of Daath (Check only one) Hospital: 10 Inpetion 2 PER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral i 27. Mannar of Death Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Division 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 12 Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier Medical 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) ATTENDING Physician D16200 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

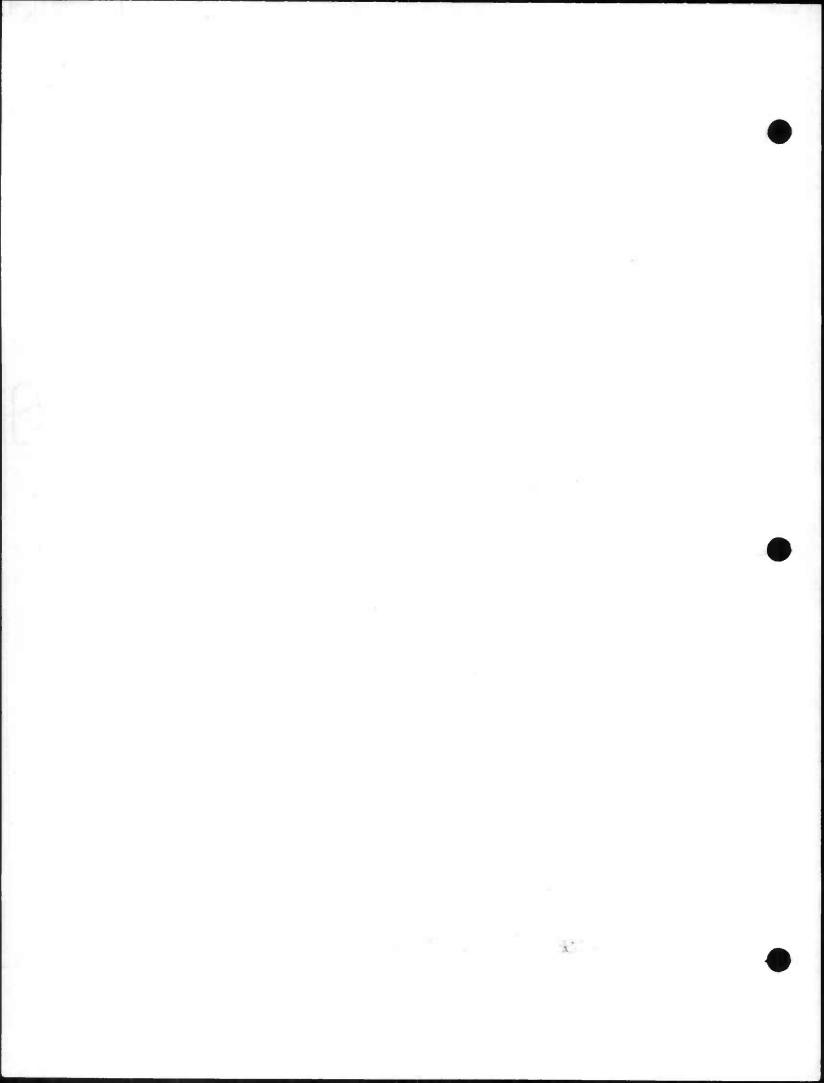
State Registrar

31. Data flied (Month, Day, Year) FEB 4 1996

M.D. 720-CMAIDEN ChOICE LA . CATONSUIlle. NORBERTO M. MACHIRAN, 32. Registrar's Signatura Win Davidson Reveall

| BALTIMORE, MARYLAND 21215-0020 | s after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | dical examiner must be notified at once. |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 6876 | ID THE HIGG-TIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FLAT DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be first written 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF HEALTH AND | MENTAL HYGIENE | | | | |
|---------------|--|---|--------------------------------|--|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | 3. TIME OF DEATH | | | |
| | Vance | Green | | | O2 O | 96 0615 A M | | | |
| | 4. SOCIAL SECURITY NUMBER | | | UNDER 1 YEAR IF UNDER 24 HRS | 7. DATE OF BIRTH (Month, Day, Year) | B. BIRTHPLACE (State or Foreign Country) | | | |
| | 251-14-8704 | 1 M 2 🗆 F | / b YRS. | | AUG.15,19. | 19 BUMBURG, S.C | | | |
| ~ | 9e. FACILITY NAME (If not institution, give a | | | b. CITY, TOWN OR LOCATION OF | | 9c. COUNTY OF DEATH | | | |
| DIRECTOR | Union HETOR | Iac Hospital | | BALTU., MA | RYLAND | π/α | | | |
| EG | 10e. STATE 10b. COUNTY | • | | OWN OR LOCATION | | 10d. INSIDE CITY | | | |
| | MARYLAND | n/a | | BALTIMORE | | 1 MYES 2 NO | | | |
| FUNERAL | 100. STREET AND NUMBER | . WE MILE | | 101. ZIP CODE 212 | 112 | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| NE | 613 GLENWOOD | AVENUE | | | | | | | |
| | 1 Never Married 2 W Merried | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | ₹ NO | 13. WAS DECENDENT OF HISI If yes, specify Cuben, Mex | icen, Puerto Rican, etc.) | Black, White, etc. | | | |
| В | 3 Widowed 4 Divorced | IF YES, GIVE WAR ON DA | ALES! | t YES X NO Spe | iony: | Specify: BLACK | | | |
| COMPLETED | 15. DECEDENT'S EDU- (Specify only highest grade | | 16e. DECEDENT'S US | UAL OCCUPATION done during most of working | 18b. KIND OF BUSI | NESS/INDUSTRY | | | |
| Ē | Elementary/Secondary (0-12) | College (1-4 or 5+) | ite. Do NOT use n | etired.) | S.T | Λ | | | |
| MP | 6 th 17. FATHER'S NAME (First, Middle, Last) | | LABOI | | | | | | |
| Ш | HAMIN GREEN | E | | ESTE | NAME (First, Middle, Melden S ELLE DAVIS | umame) | | | |
| 00 | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DDRESS (Street and Number or Rui | | State, Zip Code) | | | |
| 5 | MAE GREENE | | 613 | GLENWOOD A | VENUE, BALTI | MORE, MD 21212 | | | |
| | 20e. METHOD OF DISPOSITION 1 Guriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | . PLACE AND DATE OF I | | | ATION — Cify or Town, State | | | |
| - | 4 Donation 5 Other (Specify) | | ALTIMORE | CEMETERY | | ALTIMORE, MD | | | |
| | X 15: 11.1 | 17 | 7 | | | E. NORTH AVENUE | | | |
| 7 | Jaco many K | Jove | / | | | | | | |
| | 23. PART I. Enter the diseasea, or ahock, or heart failure. | List only one cause on a | the desth. Do not ach line. | enter the mode of dying, s | uch as cardiac or respir | Approximate interval Between Onset and Death | | | |
| | IMMEDIATE CAUSE (Fine) disease or condition resulting in death) s. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| | resulting in death) | B. DUE TO (OR AS / | CONSEQUENCE OF): | FAKT FO | TLOKE | | | | |
| z | | | CONSEQUENCE OF): | | | | | | |
| 5 | Sequentisity list conditions, if sny, leading to immediate | | | | | | | | |
| 2 | CHOOL (Discoss of Hijary | | CONSEQUENCE OF: | ARTERY DI | - SE ASE | | | | |
| CERTIFICATION | that initiated events resulting in dasth) LAST | 302.10 (011.10.1 | ounded circle or y. | | | | | | |
| | DARK II Onto a desiliant and the | a. | | | | | | | |
| CAL | PART II. Other significant condition PROSTATE | CANCER | | the undariying cause given | PERFORM | MED? AMAILABLE PRIOR TO | | | |
| MEDIC | PNOJIATIZ | 019700127 | ` | | 1 🗆 YES 2 | OF DEATH? | | | |
| Σ | DID TOBACCO USE CONT | RIBUTE TO CAUSE C | F DEATH YES | □ NO □ UNCERTA | AIN D | 1 YES 2 NO | | | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | L. CAUSE O | 28. PLACE OF DEATH | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 ≫Inpatient 2 □ ER/Outp | | THER: Nursing Home 5 Reelden | ce 6 Other (Specify) | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| | 28d. DESCRIBE HOW IN | JURY OCCURED | | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | | M t YES 2 NO | NA | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, stre | et, factory, office | 281. LOCATION (Street er City or Town, State) | nd Number or Rural Route Number, | | | |
| COMPLETED | 29e. CERTIFIER | | | | | | | | |
| MP | (Check only | | | it the time, date end place, end of the time, date end place, end of the time, death occurred at | | ner ee stated. due to the ceuse(e) end menner es stated. | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | 29c. LICENSE I | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| BE (| Willow R. | John to | 2 | | 1086 | 1 2-10-96 | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON W | _ | | int) | | | | | |
| | | ad, BALT | | P. 21212 | | | | | |
| | 31. DATE FILED (Month, Day, Year) FEB 1 4 1996 | 32. DEGISTRAR'S SIGN | ATURE *** | | | | | | |
| \square | 1 CD T # 1990 | Julia Davids | n-Handalla | £ | <u></u> | | | | |



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State of Maryland / Department of Health and Mental Hygiene 9 6 0 3 9 | 5

| 91 | 6-573-510 | 0 | State of Maryland / Department of Health and Certificate of Death | F | Reg. No. | | 9913 |
|-----------|--|----------------|--|--|------------------------------|--|---|
| | Physici | ian | Decedent's Name (First, Middle, Last) RODNEY M • GARVEY | 2. Date of Dea Month FEBRUA | | 1°9′96 | 3. Time of Death |
| | /Medi | | | Location of Death | | | 9:15PM |
| | Examir | ner | SINAI HOSPITAL BALTI | | 70. 000 | 01 000011 | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Deys Hours Mir | | h Veerl | 9. Birthpla | ce (State or Foreign |
| | Director | г | 216-96-6871 29 Yrs. | Januar | y 18, | Londo | on, Eng. |
| | and we | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | 1967 | | | d. Inside City Limits |
| | Mary Frah | to | MD Baltimore | | | | 1 💢 es 2 🗆 No |
| | or 28s | Director | 10e. Street and Number 10f. Zip Code | | 10g. Citizen of | What Countr | y? |
| | 23a | ral | 3507 Devonshire Drive 21215 | | USA | | |
| 713-0020 | 72 hours after death with the Maryland natural', or flems 23s or 28s-f show diest Examinet must be notified at | by Funeral | 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Ves, Sive Yesr or Dates: 13. Wes Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 14. Wes Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 15. Wes Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 16. Yes 2 No Specify: | Specify Yes or No- rto Rican, etc.) | 14. Rad Bla Specif | e - America ck, White, et y: Blac | C. |
| 2-0 | n 72 hours "natural", edical Exa | Completed | 15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grede completed) (Give kind of work done during most of we | orkina | 16b. Kind of B | | |
| V | E 6 E | mpi | Elementary/Secondary (0-12) College (1-4or 5+) | | | | |
| 0 7 | filed Hygie of the r | ပိ | 12th Master Barber 17. Father's Name (First, Middle, Last) 18. Mother's Na | ame (First, Middle, | Bark Meiden Suman | | |
| yland | should be filed vond Mentel Hygie marked other turnatic avent, In | To Be | | ette Se | | , | |
| Mary | s mar | - | 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or F | | | Stete, Zip C | Code) |
| ₹, ₹ | and and and and and and and and and and | | Paula Woods 3700 Elkader Rd. | | more, | | |
| 0 | If of H If ite | | 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) | Date | 20c. Location | City or Tow | n, Stete |
| pannuore, | permit. Pages 1 and 2 should be filed Department of Heelih end Mentel Hyg Important: If Item 27 is marked other any injury or other traumatic event, once. | | 4 Donetion 5 Other (Specify) Woodlawn Cemetery 0 21. Signature of Fundral Service Licenses 22. Name and Address of Facility | 2/13/96 | Wood | lawn. | Md. |
| 0 | Depariment of the popular of the pop | | | and So | n Fune | ral I | Home |
| | _ | | Leroy 0. Dyett 4600 Liberty H 233 Part. Enter the disdays, or complications that caused the death. Do not enter the mode of dying, such as cerdical shock, or hear failure. List only one bauge in each line. | eights ac or respiratory ar | Ave. E | alto | Md . Approximate 0.7 |
| | Physician /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in death) a. GUNSHOT WOWLDS TO BACK & A | | | | Onset and Death |
| | 7.353 | Jer | Due to (or as e consequence of): | | | | |
| | icate be executed physicien end s the burial-transit | dicai Examiner | Sequentially list conditions. Due to (or as a consequence of): | | | | |
| Š | icate be executed physicien end s the burial-transit | EX | Sequentielty list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or injury | | | i | |
| 00/00 | physic physic s the b | dica | that initiated events resulting in death) Last Due to (or es a consequence of): | | | | |
| X0 | ding ding | w | d | | | | |
| ă | deeth e atter | Iclai | Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. | 23h Did t | obacco usa co | ntribute to t | he cause of death? |
|) | by the | Physician/M | The state of the s | | res 2□No | 3 Proba | >/ |
| ń | requires that the de been signed by the a hould be detached f | þ | | | | | |
| ords, | v require been si should | Completed | | 24a. Was | an autopsy med? | avail | autopsy findings able prior to pletion of cause |
| 200 | hes hes | mpi | | II. den si | | | eath? |
| | certificate h | 0 | 25. Was cese referred to medical 26. Place of Dr | eath (Check only o | 'es 2□No | 1,00 | Yes 2□ No |
| | Attending Physician: or death. ector: After this certific by the funeral director, | To B | examiner? | Home 5 Resid | | ner (Specify) | |
| _ | D 0 2 | | 27. Menner of Death 1 Natural 5 Pending (Month Dey Year) 28b. Time of bound Work? 28c. Injury at Work? 1 Natural Investigation 2 7 7 6 6 | 28d. Describe h | | | |
| 2 | Attending or death. ector: After by the fune | catic | 2 Accident Investigation 2 7 96 2017 M 1 Yes 25 No | SUB | | HOT | |
| 2 | or Att | Certification: | Homicide determined 25e. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) | 28f. Location (S City or Tow | Rireet end Numi m, Stete) | per or Rurel I | Route Number |
| - | spital cours a merel l | _ | 29a. Certifier 1 Cartifying Phyaician: To the best of my knowledge, deeth occurred at the time, dete and place | e and due to the | cause(s) and m | annar as stat | MAY WORE |
| | n 24 h | edical | (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated. | | | | |
| | To the Hospital or Attendin within 24 hours after death. To the Funerel Director: At completely filled in by the fur | M | 29b. Signature and fille of certifier 29c. License number | : | 29d. Deta signe | d (Month, D | ey, Year) |
| | . 1 | | O.C.M.E. | F | ebrua | cy 8, | 1996 |
| | 4 | | 30. Name and address of person who completed ceuse of deeth (frem 23a) (Type, Print) MARO = GOLLE JR M(> 111 Penn Street | Pa1+4 | more | ма | 21201 |
| | Sta | ite | 31. Date filed (Month, Day, Year) 32. Registrar's Signeture | , Dalti | more, | rid. | 21201 |
| | | | | | | | |

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

| | | | | aryland / Depa <i>Cer</i> | tificate of | Death | | Reg. No. | 0 00010 | | | | |
|--|--|--|---|--|--|--|--------------------------------------|-----------------------------------|--|--|--|--|--|
| Physic /Medi | | Decedent's Neme (First, Middle, Las Edward Jose | | GOWER, S | r. | | 2. Dete of De Month Februar | Day | Year 996 5:13 am | | | | |
| Exami | | 4a. Facility Nama (If not institution, give Franklin Square | street end number) Hospital | | | 4b. City, Town, or Rosedal | Location of Deat | 4c. County | | | | | |
| Funeral Director | | 200 12 0/00 | 9x 7. Ag | 74 Yrs. | If Undar 1 Yaar Months Deys | If Undar 24 Hrs Hours Min | . (Month, De | th by, Year) 19,1921 | 9. Birthplace (State or Foreig Country) Freeland, Pa. | | | | |
| /and | | Usuel Residence of Dacedent 10a. Stata 10b. County | | 10c. City, Town or Lo | cation | | | | 10d. Inside City Limits | | | | |
| e Man | ctor | Maryland Baltimor | e Co. | Parkvi1 | 1e | | | | 1 ☐ Yas 2X No | | | | |
| th with the | Funeral Directo | 10e. Street end Number 3303 Acton Road | | | 10f. Zip Code 21234 | -4814 | | 10g. Citizen of V | What Country? S.A. | | | | |
| s 1 and 2 should be filed within 72 hours after death with the Manyland I Health and Mental hygiene. I then 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Exercitive must be nuclied at | | 11. Marital Status 1 Never Merried 2 Marriad 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 1 If Yas, Giva Yaar or Datas: | lo. | Vas Decedent of H Yas, specify Cub □ Yas 2 No | dispanto Origin? (S an, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | 14. Rac Bied Specify | e - American Indian, ck, White, etc. White | | | | |
| pormit. Pages 1 and 2 should be filed within 72 hours af Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or any Injury or other traumatic event, the Medical Exercising 100.68. | Completed by | 15. Decedant's Ed (Specify only highast grad Elementary/Secondery (0-12) | | +) 16a. Deced (Giva life. L | ent's Usuei Occup kind of work dona DO NOT use retire Foremar | eation during most of wo d) | orking | | l Industry | | | | |
| 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tra M | To Be Co | 17. Father's Neme (First, Middle, Last) Michael Gower | | | | | me (First, Middle rosh | , Meiden Sumen | ne) | | | | |
| alth and N 27 is mar | P | 19a. Informent's Neme/Retetionship (7. Mrs. Elizabeth W. | ype, Print) Gower | 3303 A | g Address (Street Acton Roa | end Number or R | ucal Route Nymb | er, City or Town Yland 2 | State Zip Code 1234-4814 | | | | |
| Page nent o int: If | | 20e. Method of Disposition 1 24 Burial 2 Cremetion 3 4 Donetlon 5 Other (Specify, | | 20b. Pleca of Dispos cemetery, cren Dulaney Va | netory or other pla | Gard. | Dete 02/13/9 | | city or Town, Stete ysville, Md. | | | | |
| pemit. Pag Depertment Important: I any Injury o | | Dulaney Valley Mem. Gard. 02/13/96 Cockeysville, Md 21. Signature of Funerel Sarvice Licansee Jeffrey L. Gair Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 | | | | | | | | | | | |
| Physician | 23a. Pert Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one of the each line. | | | | | | | | | | | | |
| /Medicai Examiner | | Immediate Causa (Finei disaasa or condition resulting in deeth) | ө | hemoptysis | | | | | 12 hours | | | | |
| be iii | Examiner | | | sed coagul | | | | | 1 week | | | | |
| axecut n and al-tran | Exan | Sequentially tist conditions, if eny, leeding to immediate | | Due to (or as e conseq | | | | | | | | | |
| ficete be executed physician and is the burial-transit | dicai | Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | v | nary fibros | | | | | 1 year | | | | |
| death certifice e attending ph id for use as th | - | rasulting in death) Last | d. Asbest | | | | | | 50 years | | | | |
| | Physician/M | Part II. Other significant conditions co | ntributing to death bu | it not resulting in the un | iderlying cause giv | en In Pert i. | 23b. Did | tobacco use co | ntribute to the cause of death | | | | |
| requires that the de seen signed by the a hould be detached it | by Phy | | | | | | 10 | Yes 2 No | 3 Probably 4 Unknow | | | | |
| law requires as been si | Completed | | | | | | | en eutopsy ormed? | 24b. Were autopsy findings sveilable prior to complation of cause of death? | | | | |
| The ate h | Con | | | | | _ | 10 | Yas 2 No | 1 ☐ Yas 2 ☐ No | | | | |
| Physician: this certificant | o Be | 25. Wes case referred to medical examiner? | Hospitel: | | Oth Oth | or: | eth (Check only | | | | | | |
| | | 27. Manner of Deeth | 28e. Dete of trijur | y 28b. Time of | 28c. inju | 4 LI Nursing I | dome 5 ☐ Resi 28d. Describe | dence 6 LIOth how injury occur | | | | | |
| l or Attending I efter deeth. Director: After d in by the fune | Certification: | 1 Neturel 5 Pending investigation 3 Suicide 4 Homicide Getermined | | iry - At home, ferm, stre | M 1 🗆 | Yes 2 □ No | 28f. Location (| Street and Numb | per or Rural Route Number, | | | | |
| To the Hospital or Attention 24 hours effect deet To the Funeral Director: completely filled in by the | | 29a. Certifier Certifying Phy | building, atd | f my knowledge, deeth | occurred et the til | me, dete end pleca | City or To | ceuse(s) end me | ennar as stated. | | | | |
| the H nin 24 the Fr | Aedical | una) | ner: On the basis of and menner ste | examinetion end/or inv ted. | | | urrea et the time, | | and due to the cause(s) | | | | |
| T V V | × | 29b. Signeture and title of certifier M S JO SEP | hom | 2 | RD 19 | | | 29d. Date signa 2 - 10 - | d (Month, Day, Year) | | | | |
| | | 30. Neme end eddress of person who co DR Meredith Joseph | | | | ive Balt | imore Ma | aryland | 21237 | | | | |
| Sta Registr | | FEB 1 4 1996 | ha Daloidagistra | PSHAME. | | | | | | | | | |

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| Physic | ian | Decedent's Name (First, Middla, Las JAMES | R. HIL | т | | | 2. Dete of Dea Month | Day | 3. Tima of Death | | |
| /Med | | 4e. Facility Nama (If not Institution, give | | ь | | 4b. City, Town, or L | FEBRUA | 4c. County | .996 12:56 AN | | |
| Exami Funeral Director | ner | GREATER BALTIMORE 5. Social Sacurity Number 214-58-9476 6. Se | E MEDICAL C | ENTER In yrs. last birth 43 Y | dey) If Under 1 Yeer | TOWSO | | BA | LTIMORE 9. Birthplace (State or Foreign Country) MD | | |
| and | | Usual Rasidence of Decedant 10e. Stete 10b. County | 10 | Oc. City, Town | or Location | | | | 10d. Inside City Limits | | |
| Maryle 1 sho | 5 | 7.1.3.31 | /a " | Balt: | | | | | M M Yes 2 □ No | | |
| 280 notifie | Je C | 10e. Street and Number | | 13410. | 10f. Zip Coda | | | hat Country? | | | |
| h with | Ole | 1319 Pentwood | Rđ. | | 212 | 39 | | US | | | |
| d within 72 hours after death with the Manyland glene. If then "natural", or frame 23e or 28e-f show the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status #D*Nevar Married 2 Merriad 3 Widowed 4 Divorced | 12. Was Decedant Eve Armed Forcas? ♣12¥es 2□No If Yes, Give V 1 Year or Detes: 1 | | 13. Was Decedent of Initial Yas, specify Cub | dispante Origin? (Sp an, Mexican, Puerto Specify: | pecify Yas or No- Rican, etc.) | 14. Race Bleck Specify: | - Amarican Indien, c, White, etc. Black | | |
| 72 hours "natural", | Completed | . 15. Decedent's Edi (Specify only highest grad | ucation | 16a. 0 | Decedent's Usuel Occup Give kind of work done life. DO NOT use retire | pation during most of work | kina | t6b. Kind of Bu | siness/Industry | | |
| of thin | mple | Elementary/Secondery (0-12) | College (1-4or 5+) | | | | 9 | 7. | | | |
| DEF | | 17. Fether's Neme (First, Middle, Last) | lyr. | Ca | ase Exami | ner 18. Mother's Nem | a (First Middle | | ross Blue Sl | | |
| id 2 should be file th and Mental Hy ?7 is marked othe traumatic event. | o Be | James Hill | | | | The second second | arion H | | 7 | | |
| 2 should and Menials marks | To | 19e. Informent's Neme/Relationship (T | iype, Print) | 19b. | Melling Address (Street | | | - | Stata, Zio Code) | | |
| 1 and 2 s Health ar em 27 le | | Marion Sims | | 13 | 319 Pentwo | ood Rd. | Balto. | , MD | 21239 | | |
| os 1 and of Health item 27 | | 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, crematory or other pleca) | | | | | | | City or Town, State | | |
| Pages nent of h int: if he iry or of | | 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ I | Jelliosei Itolli Sermi | 1 | 2-14 | Owings | Mills, MD | | | | |
| permit. Pages 1 ar Department of Hea Important: if item; any injury or other | | 22. Neme end Addrass of Fecility James A. Morton & Sons Funeral Home 1701 Laurens Street Balto., MD 21217 | | | | | | | | | |
| Physician //Medical Examiner patrons of age patron | il Examiner | Immediate Cause (Finei disease or condition rasulting In death) Sequentially list conditions, if any, leeding to immediate cause. Enter Undarfying Cause (Disease or injury | Du- | e to (or es a co | onsequence of): | Repai | | | 3 days | | |
| n certificate anding phys use as the | Physician/Medical | Cause (Disease of Highly that initiated events resulting in deeth) Lest | Dua to (or as a consequence of): d. | | | | | | | | |
| 6 40 | sici | Part II, Other significant conditions co | ntributing to death but n | ot resulting in | the underlying duse given | ven in Part I. | 23b. Did to | obacco use con | tribute to the cause of death? | | |
| hat the | | algured In. | mundal | Cura | y Syno | ume | 101 | 88 2 No | 3 ☐ Probably 4 ☐ Unknown | | |
| a been sign 2 should be | Completed by | | | 0 | | | 24e. Wes a | | 24b. Were autopsy findings aveilable prior to completion of cause of death? | | |
| The Land | Con | | | | | | 1□ Y | es 2 No | 1 ☐ Yes 2 ☐ No | | |
| dolane. The certificate rector, pay | Be | 25. Wes case referred to medical axaminer? | Heenitel. | | l ou | 26. Place of Dee | th (Check only or | ne) | | | |
| ding Phys h. Aharthia funecal di | ıtlon: To | 27. Manner of Death 1 DNaturei 5 Pending 2 Accident Invastigation | 28a. Deta of Injury (Month, Dey Ye | 2 ER/Outp 28b. Tir 9ar) | me of 28c. Injury | 4 U Nursing H | ome 5 Rasid 28d. Describe h | ence 6 □Othe ow injury occurre | 111111 | | |
| 호흡품도 | Certification: | 3 Sulcida 6 Could not be determined | 28e. Pleca of Injury building, etc. (5 | - At homa, fam Specify) | n, straat, factory, office | | 28f. Location (S City or Tow | itreet end Numbe n, Stete) | or or Rural Route Number, | | |
| To the Hospital Minin 24 hours To the Funeral completely filled | fedical | (Check only ane) 2 Medical Exami | elcian: To the best of miner: On the besis of exi end mannar stated | amination and/ | or investigation, in my o | pinion, deeth occur | red et the time, o | late end piece, a | nd due to the cause(s) | | |
| 0 | 2 | 29b. Signature and title of certifier | to MD - fac | ulty Pi | ypinan D | 47540 |) | 2/ | (Month, Dayl Year) | | |
| | | and eddress of peredh who co | MD, 656 | (Item 23a) (f | hartes 9 | , Battin | rose, Wi | 10 | 2/204 | | |
| St. Regist | 77.7 | FEB 1 4 1996 | P. Registrars | Pande 32 | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

| fler death. Page 6 may be retained by the hospital or attending physician. | e funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should J. | examiner must be notified at once. |
|--|---|--|
| THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | | | | | | | | | | | 91 | o U | 3918 |
|---------------|--|--|--------------------------------------|--------------------------------------|-------------|-----------------------|-------------------------|------------|--------------|---------------------------------|--------------|----------------------|--|
| | FOR 1 - STATE REGISTRAR | STATE OF N | MARYLAND / | | RTMEN | | | | MENTAL | HYGIEN REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, List) | Н. | | F , S | | | | | FEBR | UARY D | 9,199 | 6 YEAR | TIME OF DEATN 1829 M |
| | 4. SOCIAL SECURITY NUMBER 218-22-9402 | 5. SEX 1 X M 2 F | 6. AGE (In yrs. les | YRS. | MONTHS | DAYS | IF UNDER | MIN. | JAN | Day, Year) | | Country) | |
| OR | 9a. FACILITY NAME (If not institution, give st MD GENERAL | reet and number) _HOSPIT | AL | | | BAL | P LOCATI | ON OF DE | EATH | | | /A | TH |
| DIRECTOR | 100. STATE 10b. COUNTY MD HOI | WARD | | 10c. Cl | COL | | | | | | | | d. INSIDE CITY |
| | 10e. STREET AND NUMBER | | 7 3 3 7 7 7 | | 00.2 | | . ZIP CODI | | 4 | | 200 | ZEN OF WHA | T COUNTRY? |
| JNE | 10529 MORNING | | LANE IT EVER IN U.S. AF | MED | 13. | WAS DEC | | 104 | | ? (Specify Ye | | S.A | American Indian. |
| BY FUNERAL | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 IF YES, GIVE V Korean | YES 2 1 | NO | | If yee, sp | | n, Mexica | in, Puerto P | | | Black, V Specify: | BLACK |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | completed) | | CEDENT'S live kind of Do NOT L | work done | CCUPATIO during mo | ON st of workin | ng | | State | | | riate |
| COMPLETED | 12TH | 6 years | | ciat | e In | fiel | | | | | | . 75500 | |
| ш | 17. FATNER'S NAME (First, Middle, Lest) Benjamin Hoff | | | | | | 1000 | | ee By | fiddle, Meider /rd | Sumame) | . 3 | 3 12 |
| TO B | 190. INFORMANT'S NAME (Type/Print) Annette Hoff | | 19 | | | | | | | COlu | | | 1044 |
| | 20a, METHOD OF DISPOSITION 1 (C) Burlel 2 Cremetlon 3 Remote 4 Donation 8 Other (Specify) | oval from State | 20b. PLACE cemetery, cri | AND DATE | OF DISPOS | SITION /Na | rne of | III | DATE | 20c. L0 | DCATION - | City or Town | , State |
| | 4 □ Donetton e □ Other (Specify) ☐ Garrison Forest Vet 21596 Owings Mills, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | | | | | | |
| | • Cabriel | le (| COOK | | | 43 | 00 | Waba | sh A | venue | | | ld 21215 |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final | complications the List only ons car | et caused the de use on sach line | eath. Do a. | not enter | r tha mo | de of dy | ing, suc | h ss card | lisc or raap | piratory arr | est, | Approximata Interval Between Onset and Death |
| | disesse or condition resulting in death) | PUL 10 | VARY EMB | | | | | | | | | <u> </u> | |
| NO | Sequentially list conditions, | b. | (OR AS A CONSE | OHENCE | NE). | | | | | | | 0 | |
| ICATI | If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury | C | OR AS A CONSE | | | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | d, | OH AS A CONSE | DUENCE (| J+}: | | | | | | | | |
| | PART II. Other significant condition | s contributing to | dasth but not | rasuiting | in tha u | ndariyin | g cauae | given in | Part 1. | 24a. WAS AI PERFO | N AUTOPSY | A | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| MEDICAL | | | | | | | | | - | 1 X YES | 2 NO | 0 | OMPLETION OF CAUSE F DEATN? |
| N. W | DID TOBACCO USE CONTI | RIBUTE TO CA | | | | | L UNC | ERTAI | Ν□ | | | | W. rea |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | 26. PLA | | OTHE | R: | e 5 □ B | esidence | 6 Other | (Specify) | | | |
| | 27. MANNER OF DEATH 1 Neturel 5 Pending | 26a. DATE OF | F INJURY Day, Year) | 28b. TH | _ | 28c. INJ WC | URY AT PRK? YES 2 | | | CRIBE HOW | INJURY OC | CURED | |
| ED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide detarmined | 28a. PLACE (| OF INJURY — At he, etc. (Specify) | ome, term, | atreet, fac | | | | | ATION (Street or Town, State | | or Rural Rou | te Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) | | | | | | | | | | | | |
| | 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIES | | examination and/or | investigat | lon, in my | opinion, d | | red at the | | and place, a | 7 | | nd menner as stated. |
| TO BE | melska | uga. | m | D | | | | - | 263 | \$ | ≥ 29d. DAI | 219 | (96 |
| F | 30. NAME AND ADDRESS OF PERSON WH | | 200 200 100 | | | ANT | Carri | ₹DAT | HOSE | ז∆ידינ | | | |
| | S1. DATE FILED (Month, Day, Year) | | AR'S SIGNATURE | C/ U | runi. | רגייאט | الالنت | -1747 | TION | 11711 | | | |
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State of Maryland / Department of Health and Mental Hygiene

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| Physician Medical Examiner The propose and propose an | Inyland show | | | | 10c. Ci | ty, Town or Lo | cation | | | | | 1 | |
| Physician Medical Examiner The propose and propose an | W F | cto | Maryland n/a | | 1 | Baltimo | ore | | | | | | Yes 2 No |
| Physician Medical Examiner The propose and propose an | 等 9r 2l | Sire | 10e. Street and Number | | | | 10f. Zlp C | ode | | | 10g. Citizan of | What Cour | ntry? |
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| Physician Medical Examiner The propose and propose an | and and n 27 | | Rosetta Jackson | | | | | rton Road Baltimore, Maryland 21215 | | | | | 21215 |
| Physician Medical Examiner The propose and propose an | or of H | | 20a. Method of Disposition 20 1 □ ③Buriel 2 □ Cremetion 3 □ Removel from Stete | | | Pleca of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or T | | | | own, State | | | |
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| Physician Medical Examiner Physician Medical Examiner Negurinary 1 (1) | Balt permit. Depart Imports any inje | | 21. Signeture of Funerel Sarvice Licensee 22. Nema end Addrass of Facility Nutter Funeral Homes, Inc. | | | | | | | | | | |
| Physician Middleal Examiner The property of t | | | 220 Part Enter the disease or so | world and annual | | | | | | | | | |
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| Description of cause of the cause of death of the death of th | f60, te be execute ysician and te burial-trans | Ical Exam | If any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated avents | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death of the contribute to the cause of death of the cause of | - 06 | | resulting in deeth) Last | d | | | | | | | | | |
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| 25. Wes case referred to medical exeminar? 26. Place of Deeth (Check only one) 27. Magner of Deeth 1 | ecords aw requires as been sign 2 should be | pleted by | | | | | | | | 24e. Wes | s an autopsy ormed? | ev | allable prior to |
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| Second S | (E) NA | | 25. Wes case referred to medical | | | | | | 26. Place of Dea | | | 1 | |
| Second S | ysicil direc | OE | exeminar? 1 ☐ Yes ► No | Hospitel: XX Innat | lent 2 🗆 | ER/Outpatien | t 3□ DOA | Oth | or: | | | er (Specifi | v) |
| building, elc. (Specify) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29b. Signeture and title of certifier 30b. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) City or Town, Stete) 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number D26170 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Ceorge Pirpiris, M.D. c/o Maryland General Hospital | ION OI nding Phy ath. :: After thi e funeral | | Naturel 5 ☐ Pending | 28e. Dete of In (Month, D | | 28b. Time of | 28c | | y at k? | · · · · · · · · · · · · · · · · · · · | | | ,, |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medical Examination on the basis of examination end/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and menner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pebruary 8,1996 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) George Pirpiris, M.D. c/o Maryland General Hospital | 5 646 | Certifica | 3 ☐ Sulcide 6 ☐ Could not | d 28e. Pieca of it | njury - At h | ome, ferm, stre | eet, factory, o | office | | 28f. Location (City or To | (Street and Numl wn, Stete) | per or Rura | il Route Number, |
| 29b. Signeture and title of certified 29c. License number D26170 Pebruary 8,1996 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) George Pirpiris, M.D. c/o Maryland General Hospital | A P B B B B B B B B B B B B B B B B B B | | (Uneck only 2 Medical Exa | miner: On the backs | of examine | wiedge, deeth ation end/or inv | occurred et s restigetion, in | the tin | ne, dete end pleca pinion, deeth occu | , end due to the irred et the time, | ceuse(s) end me dete end placa, | enner as si and due to | tated. o the cause(s) |
| D26170 February 8,1996 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) George Pirpiris, M.D. c/o Maryland General Hospital | Within To the Comp | Σ | 29b. Signeture and title of certified | ¬ ,) | | r | 29c. L | icens | e nu <i>m</i> ber | | 29d. Date signe | d (Month, | Day, Year) |
| 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) George Pirpiris, M.D. c/o Maryland General Hospital | 1 | |) ((| 14.71 | 7,4 | , _ | | D26 | 170 | | Februa | ary 8 | ,1996 |
| 24 Date filed (Marth Cour Vers) | 5 | | 30. Neme and address of person who George Pirpiris | completed cause of | deeth (Iten | n 23e) (Type, yland (| Print) Genera | 1 H | ospital | | | | |
| | CAO | • | | | | | | | | | | | |

DHMH 16 Rev 6/95

March Service

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 6 0 3 9 2 0

| | | | | | | Cer | tificate d | of Death | R | eg. No. | 00. |) L 0 |
|---|------------------------------------|---------------------|--|--|------------|-------------------------|------------------------------------|--|--|-----------------|-------------------------------------|--------------------------------|
| Dh | voicie | | 1. Decedent's Neme (First, Middle, Last |) | | | | | 2. Dete of Dea Month | th Day | Yeer 3. | Time of Deeth |
| | ysicia Medic | _ | BERTHA ELIZABE | TH | KE | LLER | | | Februar | | | :00 P.M |
| | amin | | 4e. Facility Neme (If not institution, give | street and number) | | | | 4b. City, Town, or L | ocation of Deeth | 4c. County | of Death | |
| III YES | | | Stella Maris Hospi | .ce | | | | Towson | | Balt | imore C | county |
| Fun Dire | | | 5. Social Security Number 6. Security 15-14-7950 | x 7. Age ☐M 2⊠F | 73 | last birthdey) Yrs. | if Under 1 Ye Months De | | 8. Dete of Birth (Month, Day Nov. 10 | Year) 1922 | 9. Birthplace Country) Maryla | (State or Foreign |
| pu » | | | Usual Residence of Decedent 10e. Stete 10b. County | | 10- 03- | Taura and a | | | | | 7 | |
| e Maryla | tried at | ctor | | re County | | y, Town or Loc Owson | cation | | | | | nside City Limits Yes 2 No |
| P 29 | 9 9 | Oire | 10e. Street end Number | | | | 10f. Zlp Cod | le | 1 | Og. Citizen of | What Country? | |
| th w 23€ | 1 | je. | 2300 Dulaney Valle | y Road, A | pt. | F-308 | 2120 |)4 | | U.S.A. | | |
| 21215-0020 d within 72 hours after death with the Manyland gjene. er than "natural", or lerms 23s or 28s—4 show. | Examiner m | by Funeral Director | 11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent I Armed Forces? 1 Tyes 24 N If Yes, Give Year or Dates: | | | | of Hispenic Origin? (Sp Cuben, Mexican, Puerto No Specify: | pecify Yes or No- Pican, etc.) | | ca - American Ir ck, White, etc. | |
| 15-002 72 hours | 8 | Ped | 15. Decedent's Edu | | | 16a. Deced | 16a. Decedent's Usuel Occupation | | | 16b. Kind of B | usiness/Industr | у |
| 215 Bin 7 | Med | Completed | (Specify only highest grade Elementary/Secondery (0-12) | e completed) College (1-4or 5 | 4) | (Give I | kind of work do OO NOT use re | ne during most of work tired) | vorking | | | |
| d 2121 filed within Hygiena. | 윱 | Ö | 12th Grade | College (1-4015 | *) | Secre | tary | | | Bank | | |
| Maryland 212. 2 should be filed within the and Mental Hygiene. 7 Is marked other than | Vent | e | 17. Father's Neme (First, Middle, Last) | | | | | 18. Mother's Nem | ne (First, Middle, I | Maiden Suman | 10) | |
| Vent by Ment | tice | 2 | Thomas Unknown Tru | SS | | | | Helen U | Inknown I | entows | ki | |
| faryland 212 2 should be filed within and Mental Hygiens. Is marked other than | other traumatic event, the Madical | | 19e. Informant's Name/Reletionship (Ty | | | | | eet and Number or Ru | | | | |
| re, M Haalth Haalth | er tra | | Leonard Matthew Ke | ller | | 2300 1 | Dulaney | Valley Ro | ad, Apt. | F-308 | , Towso | n, Md. |
| of He | E E | | 20e. Method of Disposition | | 20b. P | lece of Dispos | sition (Name of letory or other | plece) | Dete | 20c. Location - | City or Town, | State |
| Pag Pag | 170 | | 1 Burlel 2 □ Cremetion 3 □ R 4 □ Donation 5 □ Other (Specify) | | | | | Cemetery | 2/13/96 | Baltin | more, M | aryland |
| Baltimore, No permit. Pages 1 and Department of Haalth Important: If item 27 | में हैं | | 21. Signature of Funeral Service License | 00 | | 22 | Name and Ad | dress of Facility | | | | - |
| m gge | any le | 4 | -M(21-) | $\sim Q$. | 2 | Jol | hn C. M | Miller, Inc , Maryland | 21 206 | Belair | Road | |
| Physic /Med Exami | Ical | | 23a. Part1. Enter the disease, or comparation of the control of th | CARCI | Non | MATIS | MEN | DINGITIS | | | Ons | rvel Between set and Death |
| - | | Je | | ATICAL | D (6 | RCIA | mm A | OF LUN | 16- | | 4 | mas |
| . Box 68760, death certificate be assecuted extending physician and | ansi. | Examiner | Sequentially list conditions | | | r es e consequ | | 0. 1207 | | | | |
| 9 9 9 | - I | EX | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury | | , | , | , | | | | | |
| 68760, ficate be av | De Dr | Ca | Ceuse (Disease or Injury that initieted events resulting in deeth) Lest |) | Due to (or | as e consequ | ienca of): | | | | | |
| of principle | 88 | 200 | resulting in deet(1) Lest | | | | | | | | | |
| BOX eath cer | - USB | and a | | d | | | | | | | | |
| deal deal | od for | SICI | Part ii. Other significant conditions con | tributing to death bu | t not resu | ulting in the un | derlying ceuse | given In Pert I. | 23b. Did to | bacco use co | ntribute to the | cause of death? |
| The law requires that the de | fetach | Physician/Medical | | | | | | | Ì ⊠ Y | es 2□ No | 3 Probably | 4 Unknow |
| IS, P | e q : | 2 | | | | | | | Della Lacalita | | | |
| COrd v require been si | one : | Completed | | | | | | | 24e. Was e perfori | | avallab | utopsy findings le prior to |
| Jec has b | 2 8 | d | | | | | | | | | of deet | tion of cause |
| at et at | page | 5 | | | | | | | 1 □ Y | es 28 No | 1 ☐ Ya | s 2 No |
| VITAL HECOLOS, Clan: The law requires the conflicate has been signed. | 6 | | 25. Wes case reterred to medical exeminer? | | | | | 26. Piece of Dee | th (Check only or | ne) | | |
| | | 0 | 1 Yes 2 No | lospitei: 1 🗌 Inpatier | nt 2 🗆 | ER/Outpatient | 3□ DOA | Other: 4 Nursing Ho | ome 5 Reside | ence XOoth | er (Specify) H | ospice |
| 2 0 | | | 27. Manner of Deeth 1 Naturel 5 □ Pending | 28e. Date of Injur (Month, Day | Year) | 28b. Time of injury | 28c. Ir | njury at Work? | 28d. Describe ho | ow injury occur | red | |
| | 7 | atic | 2 ☐ Accident investigation | | | ,, | | Yes 2 No | | | | |
| after Die | à | Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of inju building, etc. | ry - At ho | me, ferm, stre | et, factory, offi | ca | 28t. Location (St City or Town | | oer or Rural Ro | ute Number, |
| | P 0 | Š | | | | , | | | | | | |
| To the Hospital or within 24 hours at To the Funeral D | ii ye | edical | | | | | | e time, date end plece, by opinion, death occur | | | | |
| the H | teld | | one) | end menner stat | | | | | | | | |
| Neith To | 8 | 2 | | | | | | | | - 1 | d (Month, Day, | Year) |
| , | | | Mendall | Ktau | lle | reno | 0 | 2564 | 3 | 1/18 | 196 | |
| b | , | | 30. Name and address ot person who co | mpleted cause of de | ath (Item | 23a) (Type, F | Print) | | | | | |
| | | | DR. KENDALL FAULK | | | | LLEY R | D., TOWSON | , MD 21 | 204 | | |
| | State | 9 | 31. Dete tiled (Month, Day (per) | | r's Signer | | | | | | | |

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| | MD |
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| l | 633 |
| I | 11. MARITAL |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFI | CALE OF | DEATH | REG. N | 10. | | | | |
|---------------|---|--|---------------------------|---------------------------------------|-----------------------------|---|-----------------------|---|-------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | KS D. | Lavell | e | | 2. DATE OF DEATH MONTH | 8 199 | YEAR 12 | P DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 579-48-0995 | | (In yrs. lest birthday) _ | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year, Mar. 26, | | B. BIRTNPLACE (Stee Country) | te or Foreign | | |
| | Sa. FACILITY NAME (if not institution, give | | , | | OR LOCATION OF DE | EATN | | TY OF DEATN | | | |
| PO | Howard County Ge | neral Hospit | al | Colum | bia | HOW | Howard | | | | |
| <u>E</u> | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Υ : | 10c. CITY | TOWN OR LOCA | TION | | | 10d. INSID | E CITY | | |
| DIRECTOR | MD HO | ward | Col | umbia | of, ZIP CODE | | | | 2 X NO | | |
| BAI | 6334 Cedar Lane | | | 10 | | | en of what coun SA | THY? | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced | 12. WAS OECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR O | 2 NO | If yes, s | | NIC ORIGIN? (Specify in, Puerte Rican, etc.) y: | | 14. RACE — America Black, White, etc Specify: White | 24 | | |
| | 15, DECEDENT'S EDU (Specify only highest grade | | 18a. DECEDENT'S U | USUAL OCCUPAT | | 16b. KIND OF | BUSINESS/INDU | ISTRY | | | |
| COMPLETED | ernment | | | | | | | | | | |
| OME | 12 17. FATHER'S NAME (First, Middle, Lest) | None | Systems | I I I I I I I I I I I I I I I I I I I | | ME (First, Middle, Mail | den Sumame) | | | | |
| BEC | Randolph Duff Mildred Case | | | | | | | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7826 Grassy Garth, Elkridge, MD 21227 | | | | | | | | | | |
| | 20s. METNOD OF DISPOSITION Surface 2 M Cremation 3 Removal from State 20s. PLACE AND DATE OF DISPOSITION (Name of cametary, crematory or other place) Metro Crematory 9, 1996 Catonsville, Metro Crematory 1996 Catonsville, Metro Crematory | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSES. 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral 1 5555 Twin Knolls Rd. Columbia, MD 21 | | | | | | | | | | |
| | - Mugo | USKY | | | | | | | | | |
| | 23. PART I. Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) SepticeMia Due to (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | C | A CONSEQUENCE OF | , | | | | | | | |
| EDICAL | PART II. Other significant condition | | Accide~ | 1 | ng ceuse given in | | AN AUTOPS FORMED? | OF DEATH | PRIOR TO ON OF CAUSE | | |
| N: W | DID TOBACCO USE CONT | RIBUTE TO CAUSE | OF DEATH YE | S NO [| UNCERTAI | N 🗆 | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEAT | N (Check only one OTHER: |) | | | | | | |
| YSI | 1 TESY 2 NO | 1 Dimpetient 2 ER/Ou | | 4 - Nursing No | | 6 Other (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATN 1 Maturel 5 Pending Investigation | (Month, Day, Year) | 28b. TIMI | URY | JURY AT PORK? YES 2 NO | 28d. DESCRIBE NO | W INJURY OCC | URED | | | |
| | 2 Accident Investigation 3 Suicida 6 Could not be 4 Homicide determined | 26s, PLACE OF INJUF building, atc. (Sp | | treet, factory, off | ica | 281. LOCATION (Str. City or Town, S | | or Rural Route Numb | er, | | |
| COMPLETED | (Crieck Drilly | SICIAN: To the best of my kno | | | | | | | ner as stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | ii, iii iii, opiiioii, | | | | | | | |
| TO BE | Rebel W. Sn | et m. p | | | Dass | 76 | DE FE | b. 8 | 1996 | | |
| | Richard W. Smi | M.D. | 5802 Hic | Kory R | idge Rd. | Colu. | ubia | 2104 | 4 | | |
| | FEB 1 4 1996 | 32. REGISTRAR'S SIG | ENATURE | 7 | | | | | | | |
| | | The state of the s | 064 | | | | | | DNMH-16 Rev 1/89 | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Data of Death 3. The of Emath **Physician** February 8, 1996 Donald Luron Lee 6:50 p.m. /Medical 4a. Fecility Nema (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater BaltimoreMedical Center Towson Baltimore 7. Aga (In yrs. lest birthday) If Under 1 Yaer If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) June 7, 1914 9. Birthplece (State or Foreign Country) Maryland **Funeral** Days 10XM 20 F 215-18-3431 81 Yrs Director Usual Rasidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglena. Important if hem 27 is marked other than "natural", or items 23a or 28a-f shows any Injury or other trauments access the second of the second other trauments. 10b. Count 10a State 10c. City, Town or Location 10d, Inalda City Limits Baltimore Timonium 1 ☐ Yes 2 ☑ No Director Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21093 United States 135 E. Timonium Road 12. Was Decedanf Evar In U,S. Armed Forcas? 1 ⊠ Yes 2 □ No If Yas, Giva Year or Datas: 1941 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Merital Status 1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: White à 1941 Specify: 3 Widowed 4 Divorcad 16e. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education 18b. Kind of Buainess/Industry (Specify only highest grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Cab Driver Transportation 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Sumama) Be Pamella Schaible Frank H. Lee 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Gertrude C. Lee 135 E. Timonium Rd. Timonium, Maryland 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Ramovei from Stefa Dulaney Valley Memorial 2/12/96 4 ☐ Donation 5 ☐ Other (Specify) Timonium Maryland 22. Name end Addrass of Facility 21. Signefure of Funerei Service Licansas Milton J Knight Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enfer the disaesa, or combinations that caused the death. Do not enfer the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line. Approximate interval Between Onser and Deeth **Physician** /Medical Immediata Causa (Finel disease or condition rasulting in death) Examiner burial-transit Sequentielly list conditions, if any, laading to immedieta cause. Enfer Underlying Cause (Diseasa or injury that initiated evants resulting in death) Lesf and physician as the burial Records, P.O. Box 68760. Physician/Medical Due to (or as a consequanca of): 88 igned by the at be detached for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 10 3 Probably 4 Unknown by 24b. Wara autopay findings svailable prior to complation of cause of death? Completed 24a. Was an autopsy performed? peed this certificate has 2 No 1 TYas 1 Yas 2 No of Vital Physician: Be 25. Wes case rafarred to madical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 10 1 Yas 2 No 28a. Data of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Tima of 28c. injury et Work? 28d. Describe how Injury occurred DIMISION 5 Panding invastigation 1 (PNatural 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Pieca of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Or A 4 Homicida To the Hospital within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the causa(s) and manner as atedd.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. 29a, Cartifia 29b. Signatura and the of certified 29c, Licensa number 29d. Dete signed (Month, Day, Year) causa of death ((tam 23a) (Type, Print) Fairmout Ave FL 01 32. Registrar's Signatura 31. Data filed (Month, Day, Yaar) FEB Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

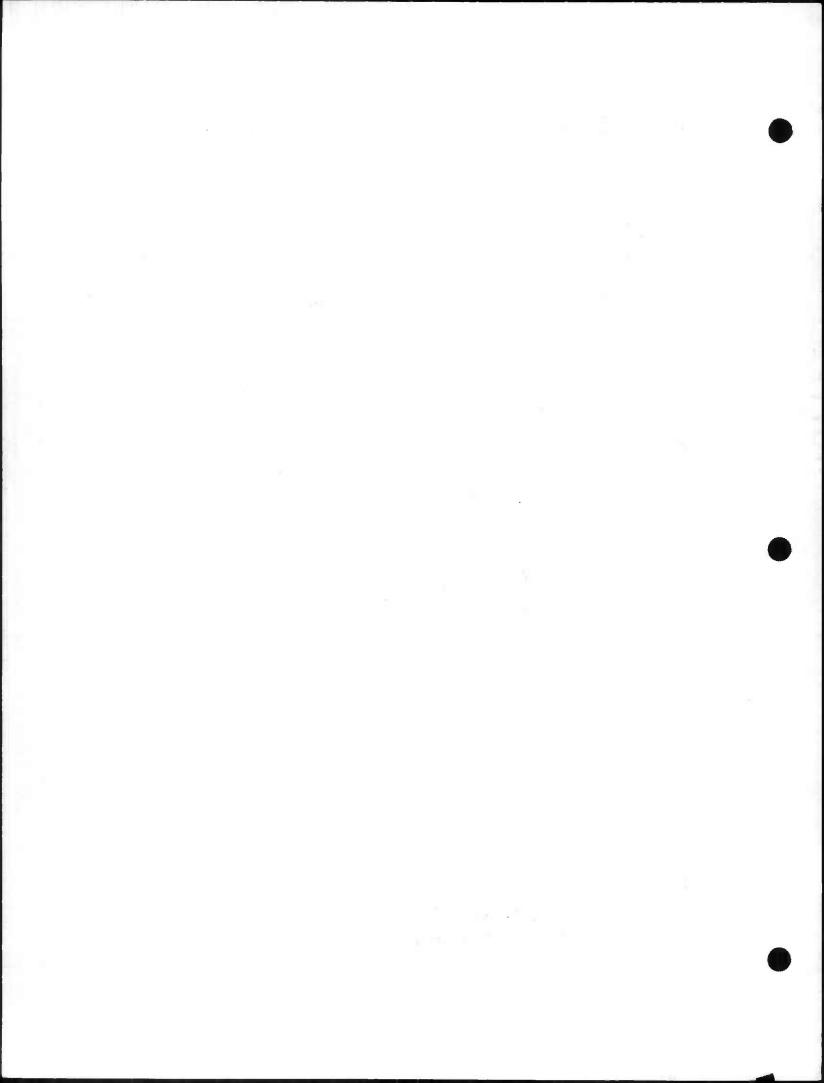
| | | | | State of Maryla | | epartment Certificate | | | ind M | | giene G | 96 | 03923 |
|------------|---|----------------|---|--|-----------------------------|--|-----------------------|------------------------------|-------------|---------------------------------|---------------------|-------------------------|--|
| | | | 1. Decedent's Name (First, Middle, Lest) | | | | | | - | 2. Date of De | | | 3. Time of Death |
| | Physici | | Mary V. M | illes | | | | | | Month | Day | Year | |
| A | /Medic Examir | | 4a. Facility Neme (#not institution, give s | | | | 4 | b. City, Tov | - | February ation of Deetl | | L996 ty of Deeth | 7:00 am |
| | LAGIIII | iei | | | | | | | | | Balton | | |
| \vdash | Funeral | | Summit Nursing Home 5. Social Security Number 6. Sex | 7. Age (In yr. | s. lest birtho | | | tosvi | | MD. 8. Dete of Bir | th | 7 | place (Stete or Foreign |
| | Director | | | M 2XF | 7 Yr | s. Months | Deys | Hours | Min. | (Month, De | y, Year) 20 1908 | | place (Stete or Foreign |
| | | | Usuel Residence of Decadent | | 1 | | | | | Ctools | 20 1908 | TVILGI | Ша |
| | how | | 10a. State 10b. County | 10c. (| City, Town o | or Location | | | | | | 1 | 0d. Inside City Limits |
| | o Ma | cto | MD Baltimore | Ca | tansvi: | lle. | | | | | | | 1 ☐ Yes 2 🖾 No |
| | ours after death with the Manylan et', or items 23a or 28a-f show Examiner trust be notified at | Director | 10e. Street and Number | | | 10f. Zip (| Code | | | | 10g. Citizen o | f What Cour | ntry? |
| | 23a | | 2210 Westchester Ave. | | | 212 | 28 | | | | USA | | |
| | dea | Funeral | | Wes Decedent Ever in Armed Forces? | U,S. | 13. Was Decede | ent of Hi | ispenic Orig | In? (Spec | cify Yes or No | - 14. Re | eca - Americack, White, | |
| 0 | or its | | 1 ☐ Never Married 2 ☐ Married | 1 ☐ Yes 2 ☑ No If Yes, Give | | 1 ☐ Yes 2 | | Specify: | 1 001101 | 110411, 010.3 | | ity: Whi | |
| 21215-0020 | within 72 hours after death with the Manyland ene. than "natural", or items 23s or 28s-f show he Mad pal Expriner trais for multipled at | d by | 3 X Widowed 4 ☐ Divorced | Year or Dates: | | 10 163 2 | 140 | Specif. | | | Spec | ny: Will | ue . |
| 2 | be filed within 72 ho ital Hygiene. Id other than "natur avent, the Med cal | Completed | 15. Decedent's Educ (Specify only highest grade | ation completed) | 16a. D | ecedent's Usual Give kind of work fe. DO NOT use | Occupa | ation furing most | of workin | g | 18b. Kind of | Business/în | dustry |
| 12 | within than than | dm | Elementery/Secondary (0-12) | College (1-4or 5+) | | | e retired |) | | | | | |
| | il Hygie other t | | unknown | | Home | maker | | 40. 14-11-1 | 4. 61 | (Films Adi tale | in the | | |
| aryland | | Be | 17. Fether's Name (First, Middle, Last) | | | | | 18. Mother | rs Name | (FIRST, MICCOLO, | , Meiden Suma | ime) | |
| Ž | should be nd Mental marked o | 2 | Chaney Palmer | | | | | | | almer | | | |
| N N | C/ 00 00 00 | | 19a. Informant's Name/Relationship (Typ | | | Mailing Address | | | | | | n, Stete, Zip | Code) |
| | other tr | | Robert C. Miller - Son 20e. Method of Disposition | | 604 | Alvin Ave | e. Ca | itonsvi | lle, | | | Oh T | Chah |
| 0 | Pages nent of 8 int: If its iry or of | | 1 Bunel 2 ☐ Cremation 3 ☐ Re | | cemetery, | cremetory or of | her plec | e) | - | Date | 20c. Location | 1 - City or To | own, State |
| Itimore, | | | 4 ☐ Donation 5 ☐ Other (Specify) | | ood She | * | | | | 14–96 | Ellicott | City, | MD |
| Ba | Departr Departr Imports any Inje | | 21. Signature of Funerel Service License | mo0544 | | 22. Name end | | RAL HO | | 7\ | | | |
| | 707 e o | | Wm. G. Sne | ith | | | | TTY, M | | | | | |
| | D11-1 | | 23e. Part1. Enter the disease, or complic shock, or heert fellure. List only one | ations that caused the de e cause on each line. | ath. Do not | enter the mode | of dying | g, such as o | cardiac or | respiratory a | | | Approximete fnterval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final | 2 | 0.4 | 7.7.1 | 0. | | Tool | 11000 | 1 400 | + | 34005. |
| | Examiner | | disease or condition resulting in death) a. | 210. | en | uuu | N | 7 | ee | ule | Inco | -// | 2960% |
| | | ē | | Due to | (or as a co | neequence of): | MI | 200 | A | obi | vas | 10. | 10,000 |
| | be executed sician and burial-transit | Examiner | Convention the tipe conditions | Due to | COL BE B COL | nsequence of): | | ax | , 46 | 27770 | | Le ! | 10 graes |
| oʻ. | be executed ician and burial-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying |) Bue to | (0) 43 4 601 | isoqualios oi). | | | | | | | |
| 760 | e 5.0 | cal | that initiated events | Due to | for as a con | nsequenca of): | | | | | | - | |
| 89 | | bel | resulting in death) Last | | (0, 00 0 00. | | | | | | | į | |
| Box | h cer endin | N. | d. | | | | | | | | | - | |
| m m | death e att | Physician/Med | Part II. Other significant conditions conti | ributing to death but not re | sulting in th | ne underlying ca | use give | en In Part I. | | 23b. Dld | tobacco use c | ontribute to | the cause of death? |
| Ö | t the by th | hys | • | | | to directly mg ou | ooo girr | | | | Yes 2 No | | |
| o. | ned o de | by P | | | | | | | | | | | , |
| Hecords, | v requires that the death certifica been signed by the attending ph should be detached for use as the | | | | | | | | | | en eutopsy | 24b. W | ere autopsy findings allable prior to |
| ပ္တ | - 20 00 | piet | | | | | | | | pend | ormed? | CO | mpletion of cause death? |
| | The law ate has b page 2 s | Completed | | | | | | | | 10 | Yes 2 No | 1[| Yes 2 No |
| | | BeC | 25. Was case referred to medical | | | | | 26. Place | of Deeth | (Check only o | | | 70 |
| 2 | Physician: this certific cal director, | 0 | examiner? | spital: 1 ☐ Inpatient 2[| ☐ ER/Outpa | atlent 3 DO/ | Othe | ne: 9 | | | dence 8 🗆 O | ther (Specif | (v) |
| | | T:U | 27. Manner of Death | 28a. Dete of Injury (Month, Dey Year) | 28b. Tim | | Sc. Injury Work | | | | how Injury occi | | ,, |
| 0 | art. r: Attar se fune | atio | 1 Natural 5 ☐ Pending 2 Accident Investigation | (Month, Day Year) | Inju | M | | Yes 2□N | lo | | | | |
| N S | 1000 | Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At building, etc. (Spec | | , street, factory, | office | | 2 | 8f. Location (. City or Tox | | nber or Rure | al Route Number, |
| 5 | 250 | Ce | | boliumg, etc. topec | y/ | | | | | only or ro | ,, 0,0,0, | | |
| / | Hosp Foreign | edicai | 29e. Certifier 1 Certifying Physic (Check only one) | clan: To the best of my kr ar: On the basis of examin | nowledge, d nation and/o | eath occurred e | t the tim In my op | e, date and binion, death | l place, ar | nd due to the d at the time, | cause(s) and r | nenner as s | tated. o the cause(s) |
| | To the comple | Med | 29b. Signeture and title of cartifier | end manner stated. | | 290 | License | number | | | 29d. Date sign | ed (Month | Day Yearl |
| | 5 1 × 0 0 | ATI | 1/1/2 | 171 | 7 | | | | 211 | | 2/1 | 2// | |
| | | - | XIVIAN | 101, | | | 2 | 62 | 14 | | 7/1 | 4/7 | 8 |
| | 0 | | 30. Name and address of person who com | pleted cause of death (ite | em 23a) (Ty | | | Mr | 210 | 29 | | | - |
| | | • | 31. Date filed (Month, Day, Year) | 1. 3p Registrer's Gig | Tature - | Balt | 0 . | [11] | 0/10 | 101 | | | |
| | Sta Registr | | 31. FEB 14 1996 | the Davidson-As | ndelle | | | | | | | | |

Registrar

Diane

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MADORTANT If item 28 is married or liem 23 shows any injury or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|
| 2 | 2 % | 2 |

| Ite | m27, FGH.m732,2/14/96,1t s | STATE OF MARYLAND | | OF HEALTH AND | | YGIENE EG. NO. | | | | | |
|---------------|--|---|---|---|---------------------------------|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Willie Jesse | Moore | | | 2. DATE OF D MONTH Februa | DAY 1998 | | | | | |
| | | SEX 6. AGE (In yrs, le | YRS. IF UNDER | 1 YEAR OF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF B (Month, De) | 17, 1921 8. 1 | Country . C · | | | | |
| TOR | 9a. FACILITY NAME (If not institution, give street | and number). OSPI tal | 9b. CITY | TOWN OR LOCATION OF C | DEATH | eath Sc. Country of Death | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | IA | 10c. CITY, TOWN C | OR LOCATION | | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 2623 Quan | this Au | e | 101. ZIP CODE 2 2 1 2 | 5 | 10g. CITIZEN | OF WHAT COUNTRY? | | | | |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO | WAS DECENDENT OF HISP/ If yes, specify Cuban, Maxic 1 YES 2 NO Spec | en, Puerto Ricen | | RACE — American Indian, Black, White, atc. Specify: Black | | | | |
| APLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade complete the specific only highest grade complete (0-12) | (pleted) | Give kind of work done to. Do NOT use retired.) | during most of working | Ba | to Gas- | + Elec Co | | | | |
| BE COMPL | 17-FATHER'S NAME (First, Middle, Last) | ore | | 18. MOTHER'S N | . // | Maiden Surname) | | | | | |
| TO E | JUST DE MANE (Type/Print) | oore ! | 2623 | Street and Number or Aura | Ave Ave | Balto, 1 | nd 2 1215 | | | | |
| | 20e/METHOD OF DISPOSITION 10. Burlel 2 Gremation 3 Removal from State 20b)PLACE AND DATÉ OF DISPOSITION (Name of the place) 20c) PLACE AND DATE OF DATE OF THE PLACE AND DATE OF THE PLACE AN | | | | | | | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICENS | March | 227 | Name and address of a Namh f 4300 wa | H-We bash | stave | | | | | |
| | 23. PART I. Enter the diseases, or com- ahock, or heart feliure. Liet IMMEDIATE CAUSE (Finel disease or condition resulting in death) | pilications that caused the conjugate on each ile | ulmona | | | or respiratory arrest | Approximata Interval Between Onset and Death 36 hours | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | DUETO (OR AS A CONSI | Failure EDUENCE OF: Ure (Ac | inte) | | | 36 hours | | | | |
| MEDICAL (| PART II. Other algnificant conditions co | ontributing to deeth but not | t resulting in the u | nderlying cause given i | | WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH? | | | | |
| AN: ME | DID TOBACCO USE CONTRIB | | | | IN 🗆 | 1 | 1 TES 2 X NO | | | | |
| PHYSICIAN: | | OSPITAL: Appatient 2 ER/Outpatient | 3 DOA Check | | 6 Other (Sp | ecify) | | | | | |
| BY PH | 27. MANNER OF CEATH 1 Natural 5 Panding 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 2ad. DEŞCRII | BE HOW INJURY OCCUR | ED | | | | |
| ETED B | 3 Suicide 6 Could not be 4 Hornicide determined | 28a. PLACE OF INJURY — At I building, atc. (Specify) | homa, farm, street, fac | tory, office | 281. LOCATIO City or To | N (Street and Number or F wn, State) | Burel Route Number, | | | | |
| COMPLE | eme) | N: To the best of my knowledge, on the basis of examination and/o | | | | | ause(s) and mennar as atated. | | | | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER ROUNT MD 30. NAME AND ADDRESS OF PERSON WHO CO | - Resident Ph | ysician | 29c, LICENSE NI AS 2402 | 321/RD9 | 319 John | GNED (Morth, Day, Year) wary 7, 1996 | | | | |
| 1 | Roselya DeWitt | 7401 W Ral | redere A | reme Balt | imore, | MD 2121 | 5 | | | | |
| | 31. DATE FILED (Magn. Day, Year) 32. AEGISTRAR'S SIGNATURE FEB 1 4 1996 32. AEGISTRAR'S SIGNATURE | | | | | | | | | | |



TRANSPITATION OF VITAL RECORDS, F.O. BOA 6070

TRANSPITATION OF ATTENDIOR PASSION The law requires that the death carificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The FURFALL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burial, cremation, or removal.

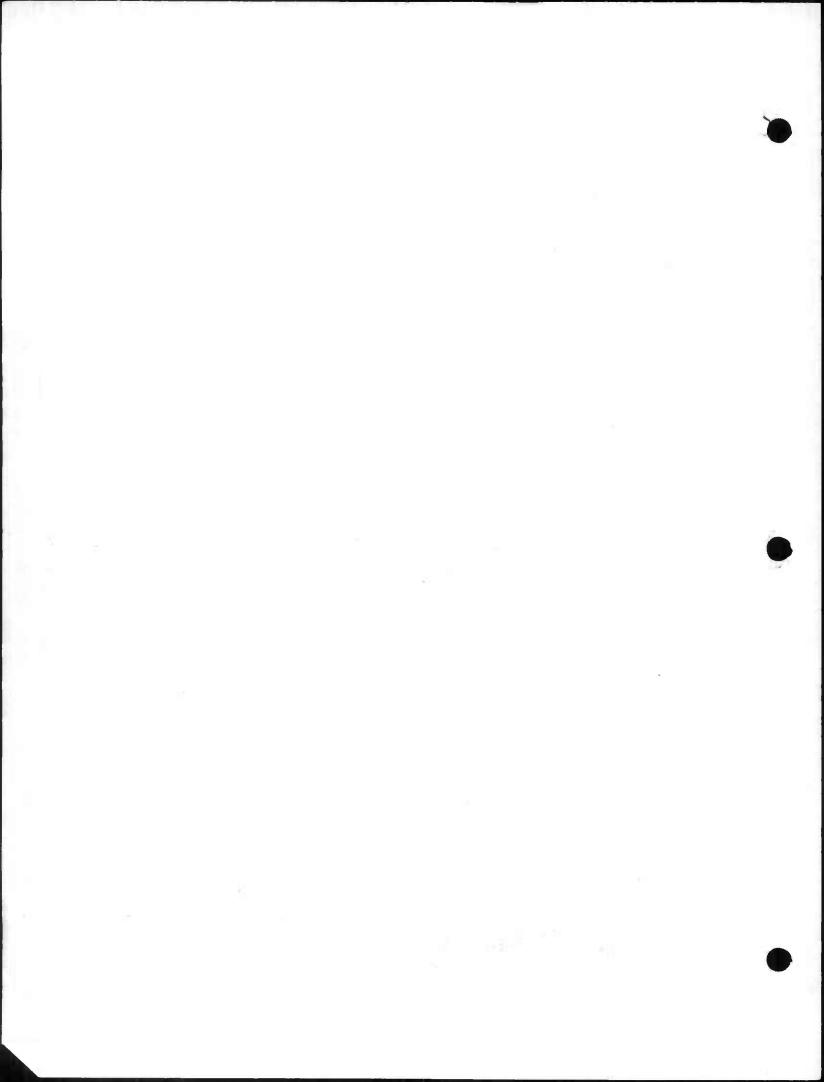
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 6876

| | 1 - STATE OF MARYLAND / DEPAR REGISTRAR CERTIF | RITMENT OF HEALTH AND FICATE OF DEATH | MENTAL HYGIENE REG. NO. | | |
|-------------|--|---|---|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | IOAIE OF DEATH | 2. DATE OF OEATH | | 3. TIME OF DEATH |
| | Howard Marshall | | FEDTUCIN 18 | 1991 | 11:35 Am |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthdey) | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | IRTHPLACE (State or Foreign puntry) |
| | 9s. FACILITY NAME (If not institution, give street and number) | At A124 22010 On LOAD 100 | Dec 20,19 | 131 | D. C. |
| <u>~</u> | Sing! Have a trib | 96. CITY, TOWN OR LOCATION OF D | EATH | 9c. COUNTY C |) A |
| 6 | RESIDENCE OF DECEDENT | DalTimore | | | 7 F |
| DIRECTOR | 1.1 | TY, TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? |
| | 10s. STREET AND NUMBER | 101. ZIP CODE | | 10a. CITIZEN | t X YES 2 NO |
| ERA | 5327 Cuthbert Avenue | 21215 | | L | 1.5A |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPA | | or No- 14. F | ACE — American Indian, Black, White, etc. |
| BY F | t Never Married 2 M Married IF YES, GIVE WAR OR DATES | If yes, specify Cuban, Mexic 1 TYES 2 NO Speci | | | Spectly: Black |
| | | USUAL OCCUPATION | 16b. KIND OF BUS | INESS/INDUSTI | |
| COMPLETED | (Specify only highest grade completed) (Give kind of life. Do NOT u | work done during most of working | | | |
| MP | 1.40 | es | Chemi | cal | Plant |
| 3 | 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S N | AME (First, Middle, Maiden S | Sumame) | |
| H | Robert Walker Marshall | Cathe | | mor | |
| 2 | Jacque (ne Marshall 1060 | O AOORESS (Street and Number or Rural | DOLL BY | State, Zip Code | id 21212 |
| | 20a, METHOD OF DISPOSITION | OF DISPOSITION (Name of) | | CATION — City of | |
| | 1 Burial 2 Cremation 3 Removal from State Crematory or Crematory or 4 Donation 5 Other (Specify) Crematory or Crematory o | inerpiece VEM Park | 12/17/96 Ba | Himo | ra Md |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF F | ACILITY | | 21215 |
| | Dabrielle (one | Macch 1 H | Wabush | Augnu | · Baltond |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do shock, or heart tailure. List only one cause on each line. | not enter the mode of dying, su | ch as cardiac or reapir | atory arrest, | Approximate interval Between |
| | IMMEDIATE CAUSE (Finsi | | | | Onset and Death |
| | resulting in desth) aACTC AC | closis | | | 9 hrs |
| | Pschemic | halpt | | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediata | | | | |
| 3 | CAUSE (Disease or Injury | | | | |
| E | that initiated events reaulting in death) LAST | OF): | | | |
| EH | d | | | | |
| CAL | PART II. Other algniticant conditions contributing to death but not resulting | in the underlying cause given in | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 1 = 1 | Metastatic prostate carrier | P | 1 🗆 YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| MED | DID TODA COO LICE CONTENDED TO CALLES OF DEATH A | TO EL MO EL MAGENTA | | | t 🗌 YES 2 🗍 NO |
| SICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH 27. PLACE OF DEATH 28. PLACE OF DEATH 29. PLACE OF DEATH 20. | ES NO UNCERTA | N L | | |
| SICI | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Impatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residence | 8 Other (Specify) | | |
| | 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TII | | 28d. DESCRIBE HOW IN | JURY OCCURE | 0 |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | M 1 YES 2 NO | | | |
| ED | 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, ferm, building, etc. (Specify) | street, factory, offica | 281. LOCATION (Street a City or Town, State) | nd Number or R | ural Route Number, |
| ᇤ | | | | | |
| M | 29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occur | | | | |
| COMPL | 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation | | | | |
| BE | 296 STONATURE AND TITLE OF CONTIFIER | 29c. LICENSE NU | IMBER | 71 | INED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typ | e, Print) | 746 | TOW | ary 10,1996 |
| | Sinai Armellal of Rultimore | James C. He | J.M MON | | , |



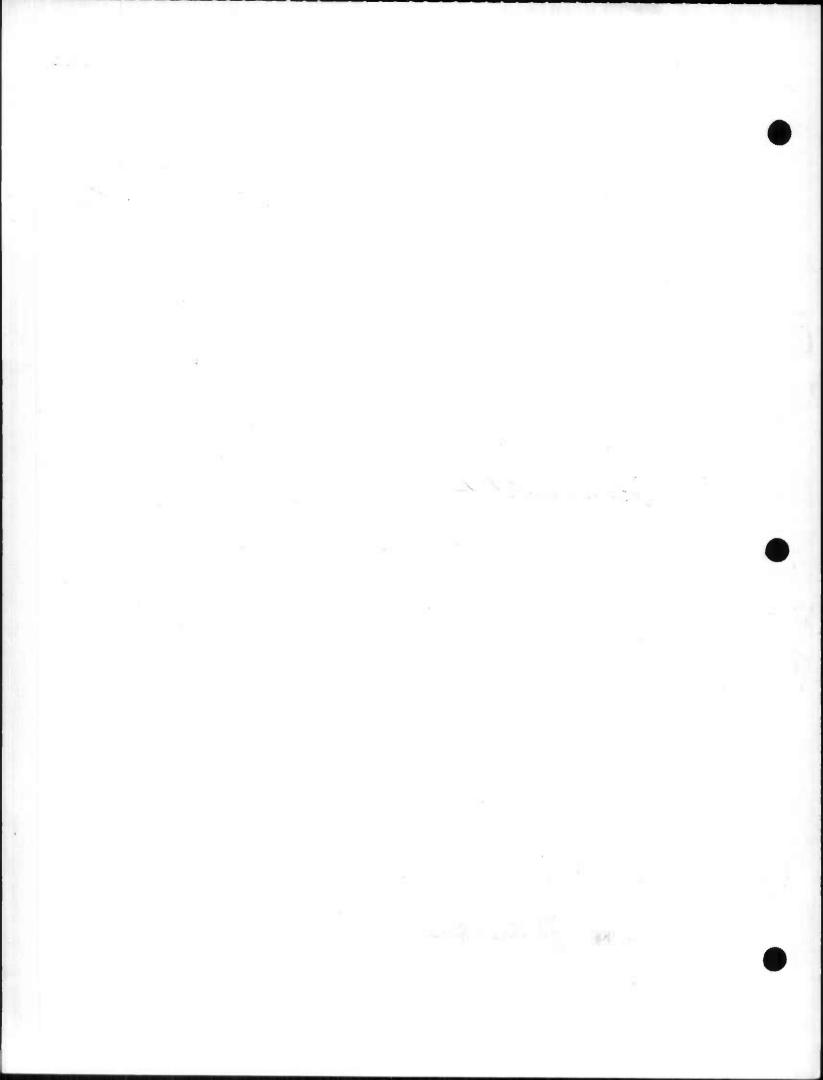
31. DATE FILED (Month, Day, Year)
FEB 1 4 1996

32. REGISTRAR'S SIGNATURE



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| TANDERS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be ref | THE FUNDAM DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 s | the same of the sa |
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| | REGISTRAR | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| | 1. DECEDINT'S NAME (First, Middle, Last) | 1 | | ucla | rtney | TON DE DE ATT | 198, 199 | 6. 09/6 A |
| | 4. SOCIAL SECURITY NUMBER 358-14-8344 | 1 - M 2 / | 6. AGE (In yrs. last | YRS, MONTHS | DAYS HOURS MIN. | 05 05 | 8 10 | BIRTNPLACE (State or Foreign Country) |
| | 98. FACILITY NAME (If not institution, give HOWARD COUNT RESIDENCE OF DECEDENT) | street and number) | AL Hos | PITAL | COLUMBIA | MD. | 9c. COUNTY | WARD |
| | Maryland Howar | | | West Frie | endship | | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO |
| | 3347 Rosamary Lane | | | | 101. ŽIP CODE 21794 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 | 10 | WAS DECENDENT OF NISP If yee, specify Cuban, Maxi 1 ☐ YES 2 10 NO Specify NO | can, Puarto Rican, etc. | | RACE — American Indian, Black, White, etc. Specify: White |
| 200000000000000000000000000000000000000 | 15, OECEOENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | | (Gi | . Do NOT use retired.) | during most of working | | BUSINESS/INDUST | FRY |
| | 12+ 17. FATNER'S NAME (First, Middle, Last) Robert A. Cook | | HO | nemaker | | NAME (First, Middle, Ma | ne hame Niden Surname) | |
| | 19a. INFORMANT'S NAME (Type/Print) | | | | \$ (Street and Number or Run | | | de) |
| | Ms. Sharon I. Rissal 20e, METNOD OF DISPOSITION 1 Burlel 2 (**Cremation 3 Rei 4 Donation 5 Other (Specify) | | cemetery, cre | and DATE OF DISPO | | DATE 200 | c. LOCATION — City | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | un Sla | 1 | 22. S1 | ton Crematory NAME AND ADDRESS OF Lack Funeral H | FACILITY | | ty, Maryland |
| | | complications that by List only one cause | coused the dase on each line | sath. Do not ente | NAME AND ADDRESS OF | FACILITY | llicott Cit | ty, Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE L 23. PART I / Entar the diseases, or ahock, or heart failure immediate cause (Final disease or condition | a. CA DUE TO (DUE TO (C. GO) | ceused the dase on each line | eath. Do not ente C Ar OUENCE OF): Lexptc OUENCE OF): Ath | NAME AND ADDRESS OF | orre, P.A. E uch as cardiac or r | llicott Cir eapiratory arrest | Approximate intervel Batwo |
| | 23. PART I Enter the diseases, or ahock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. CA DUE TO (c. DUE TO (d. | Coused the dasse on each line ORDIAG ORAS A CONSECUTION | DUENCE OF): ATMODIATE OUENCE OF): ATMODIATE OUENCE OF): | NAME AND ADDRESS OF Lack Fineral H r the mode of dying, so rest coronarc | FACILITY OTTO: P.A. E. uch as cardiac or r W. Chisa Lin Pert I. 24a. WA. PEI | llicott Cir eapiratory arrest | Approximate Intervel Batwood Onset and Do On |
| | 23. PART I Enter the diseases, or ahock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition of the con | a. CA DUE TO (b. DUE TO (c. DUE TO (d. DUE TO (| Coused the dasse on each line of the line | STATE OF THE PERSON OF THE PER | NAME AND ADDRESS OF Lack Fineral H r the mode of dying, so rest Coronarc enderlying cause given | In Part I. 24a. WA PEI | eapiratory arrest | Approximate Intervel Batw Onset and De MINVTO |
| | 23. PART I Enter the diseases, or ahock, or heart failure immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or conditions in the conditions of th | a. CP DUE TO (b. DUE TO (c. COMPLETO (d. DOBE CONTRIBUTE TO CAI TRIBUTE TO CAI HOSPITAL: 1 Inpetient 2 | Coused the dasse on aach line on aach line on aach line on ach line on ach line on ach line on a consecutive of the consecutive | DENCE OF): Teaulting In the unit of the control of | NAME AND ADDRESS OF Lack Fineral Hr the mode of dying, so rest Coronard Cor | In Part I. 24a. WA | BAN AUTOPSY REORMED? | Approximate intervel Batwo Onset and De WINVTO |
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 6 0 3 9 2 7

| | | | | | Certific | cate of | Death | | Reg. No. | | | |
|---|------------------|---|--|-------------------|-----------------------------------|---------------------------------|--|---|------------------------------------|------------------------------|---------------------|---------------|
| | | 1. Decedent's Neme (First, Middle, L | nst) | | | | | 2. Dete of De | eth | | 3. Time | of Death |
| Physi | | FARRY L | FE M | 1 50 | 1/ | | | Month | Dey | Year 996 | 9.4 | - PHS |
| /Med | | 4e. Facility Neme (If not institution, gi | ve street end number) | 4 20 | V | | 4b. City. Town. o | FEB or Location of Deati | | | 1.73 | |
| f Exam | mer | | | | 1 / | | | IMORE | 1 | V/4 | | |
| | - | GIFT OF HOPE 5. Sociel Security Number 6. | Sex 7. Ag | e (In yrs. last b | intholous If U | nder 1 Year | If Under 24 Hi | S 8 Date of Bir | | | an /Ctata | as Familia |
| Funera Directo | | | 102M 20F | 36 | Yrs. Mon | Ihs Deys | Hours Mi | rs. 8. Date of Bir (Month, Da | y, Year) | | | or Foreign |
| Directo | ' | Usual Residence of Decedent | | 36 | | | | JAN / | 4, 1959 | 17 | 0. | |
| and land | | 10a. State 10b. County | | 10c. City, Tox | wn or Location | | | | | 10 | d. Inside | City Limits |
| Mary 4 sh | 5 | mD $N/$ | A | RAI | Timol | DF | | | | | - | s 2 No |
| 289 | 5 | 10e. Sireel and Number | | DAL | | . Zlp Code | | | 40 02 | 450 | 0 | |
| 5 0 8 | 급 | | | | 101 | | ~ | | 10g. Citizen of \ | | yr | |
| er death with the Maryland Herre 23a or 28a-f show Net routh be notified at | Funeral Director | 2208 CECIL . | T | | | 2/2/ | | | US | | | |
| | 5 | 11. Marital Status | 12. Wes Decedeni Armed Forces? | / | 13. Was D | ecedent of h specify Cubi | Ilspanic Origin? en, Mexican, Pue | (Specify Yes or No erto Rican, etc.) | - 14. Rac Blac | e - America ck, White, et | | |
| 0 4 - | by F | 1 Never Merried 2 Merried | 1 ☐ Yes 2 ☑1 If Yes, Give | No | 1 ☐ Ye | s 200 No | Specify: | | Specify | · BLA | 114 | |
| 5-002(72 hours a natural; o | | 3 Widowed 4 Divorced | Year or Dates: | | | | | | | DLA | ICK_ | |
| | Completed | 15. Decedent's E (Specify only highest gi | ducation ade completed) | 168 | a. Decedent's (Give kind or | f work done | during most of w | vorking | 16b. Kind of B | usiness/Indu | stry | |
| 2 章 章 2 | 횬 | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | life. DO NO | | | | RESTU | 00. | 7 | |
| C Series | ပ္ပိ | (12) | NA | | HEL | PER | < | | NESIU | KAN I | | |
| ore, Maryland 2. 1 and 2 should be filed w f Health and Mental Hygier flem 27 is marked other th | Be | 17. Father's Name (First, Middle, Las | | | | | 18. Mother's N | eme (First, Middle, | Maiden Surnan | ne) | | |
| Via Went Went wite | 2 | SAUL JONES | ř | | | | ELIZA. | bETH | | MI | 4501 | ~ |
| and and | 1 | 19a. Informent's Neme/Relationship | (Type, Print) | 19 | b. Meiling Add | ress (Street | and Number or I | Rural Route Numb | er, City or Town, | State, Zip C | Code) | |
| e, M and 2 health m 27 I | } | ELIZABETH | MASON | 2 | 208 | CECIL | LAVE | BALT. V | nD 2 | 1218 | ~ | |
| of He | 1 | 20a. Method of Disposition | | | of Disposition | | | Date | 20c. Location - | City or Tow | m, Stete | |
| Z 0 - = 0 | | 1 12 Burial 2 ☐ Cremation 3 E 4 ☐ Donation 5 ☐ Other (Speci | | mT | 7 in al | or other pre- | rTEDIL | 2/14/01 | 1 ANSW | louine | = " | 20 5 |
| Baltim bemit. Pa bepartmen important: any lojury | | 21. Signelure of Funeral Service Lice | -7 | .,,, | 22 Nam | and Addre | es of Facility | 2/14/96 BETTS | Tune | on! | Hoe | nD |
| Balti permit. I Departm Importar any Inju | | A. 101 1. | 1/1. | 4 | | o ano radio | as or racinty | 06/13 | FUNCA | C// _ | ,,,,,, | |
| | | querry | ruon | Mille | | | | IF ST B | | h D 2 | -121 | 3 |
| | | 23a. Part 7. Enter the disease, or con- shook, or heart failure. List only | plications that caused one cause on each lir | the death. Do | nol enter the | mode of dylr | ng, such es cardi | ac or respiratory a | rrest, | | Approxima | ate etween |
| Physician | | | | | | | | | | | Onset and | Death |
| /Medica | _ | Immediate Cause (Finel disease or condition | a. centra | nerva | 215 54 | stem | toronle | a smassis | | | yea | 0 |
| Examine | | resulting in death) | | D | | | | | | 1 | 7 - 4 | |
| | Je l | | mauire | d im | Miliai | dofic | il war | syndr | 0000 | Q | W 14 1 | lears |
| 8760, ate be executed hysician and the burial-transit | Examiner | Sequentially list conditions | | Due to (or as a | | | rency | syrias | TITUL | | TUT C | 1003 |
| O, an an ar | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | | | | | | | | | |
| Box 68760, eath certificate be ex attending physician for use as the burial | edicai | that initiated events | C | Due to (or as e | CORSOCIIONO | of): | | | | | | |
| fical 68 | 8 | resulting In death) Lest | | D 00 10 (01 03 0 | oonsequence | 01). | | | | | | |
| Cent cent | 3 | • | d | | | | | | | | | |
| Boy leath ce attendii | Physician/ | Doct II Only and a state | | | rialis and re | | 30 Dil. | | | | | |
| P.O. that the de by the detached | N S | Part II. Other significant conditions | contributing to death bu | ut not resulting | In the underlyii | ng cause giv | en in Part I. | | lobacco uss co | | | |
| P that if | | | | | | | | 10 | Yes 2 No | 3 Probe | ibly 4 | Unknown |
| (ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit | l by | | | | | | | | 1177 | | the state of | |
| OF negu | Completed | | | | | | | 24a. Was | an autopsy rmed? | 24b. Wer | lable prior | rto |
| Rec e law has b | d | | | | | | | | | of de | pletion of eath? | cause |
| The la | 0 | | | | | | | 10 | res 2 No | 10 | Yes 25 | No No |
| Vital I | Be | 25. Was case referred to medical | | | | | 28 Place of D | eath (Check only o | | | | , |
| of Vital Records, Physician: The law requires the this certificate has been signeral director, page 2 should be | 0 | exa <i>m</i> iner? 1 ☐ Yes 2 🛣 No | Hospital: | ni 2 ERVO | utnatient 3 | DOA Oth | 0.00 | Home 5 ☐ Resid | | or (Specify) | haso | nice. |
| | Ë | 27. Manner of Deeth | 28a. Date of Injur | y 28b. | Time of | 28c. Injur | | | now injury occur | | | |
| On ding in the funer | 후 | 1 ANatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | Year) | Injury M | | k? Yes 2⊡No | | | | | |
| Oivision or Attending after death. Director: After fin by the fune | Certification: | 3 Suicide 8 Could not b | 00 00 01 | inv - At home for | | | | 28f Location (| Street and Numb | er or Rurel i | Route Nu | mher |
| 그 등 등 등 | Ē | 4 ☐ Homicide determined | building, etc | | ami, street, iat | story, ornice | | City or Tov | | or or righter | 10010 140 | moor, |
| 3 5 3 6 | | 20a Cadillar - No and In - Da | - International Testing | d = 1 = 1 = 1 = 1 | | | | | | | | |
| To the Hos within 24 hd To the Funa completely fi | edical | 29a. Certifier 1X Certifying Pt (Check only one) 2 Medical Example (Check only one) | nysician: To the best of miner: On the besis of | examination ar | e, deeth occur nd/or investiga | red at the tin tion, in my o | ne, dete and plea pinion, deeth oca | ca, end due to the curred et the time, | cause(s) and ma date and place, | inner as ata and due to t | ted. he cause | (s) |
| To the Hos within 24 h To the Fun completely | Mec | une) | and manner sta | ited. | | | | | | | | |
| 5 4 5 8 | - | 29b. Signature and title of certifier | | 0 | | 29c. Licens | | | 29d. Date signer | | ey, Year) | |
| 0 | | Sara Cosgn | ore, M | · U. | | N24 | 93 | | 2/13/ | 16 | | |
| | | 30. Name and address of peraon who | completed cause of de | eath (Item 23a) | (Type, Print) | | | | | 1 - | | |
| V | | Sara Cosgrove T | ower 110 J | ohns H | phins | Hospi | ital Ba | thimore, | Marylan | nd 2 | 128- | r |
| Si | ate | 31. Date filed (Month, Day, Year) | 32. Registra | - | | | | | | | | |
| | | CCD 1 / 1006 | TA STATE OF THE ST | WIPUAN | | | | | | | | |

The second of th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death Mastin **Physician** 2 9.25 AM alan /Medical 4a Facility Name (If not institution, give street and number)
Carroll County General Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster 5. Social Security Number 6. Sax 1X M 2□ F 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth
Jan. 3, 1913 9. Birthpiaca (State or Foreign **Funeral** Months Days Hours 83 Mary Yand 213-05-0551 Yrs. Director Usuai Rasidanca of Decedant the Maryland 10c. City, Town or Location Boring 10a. Stata 10d. Insida City Limits
1 ☐ Yas 2 ☐ No Baltimore 28a-f show the Medical Examiner must be notified at Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 0 Peges 1 and 2 should be filed within 72 hours after death with 5110 Frye Road 21020 USA 234 Funeral "natural", or items 14. Raca - American indian, Black, Whita, atc. 11. Maritai Status 12. Was Decedant Evar in U.S. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Armed Forces 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 If Yas, Giva Year or Datas: 1 ☐ Yas 2XXNo Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Unknown Collaga (1-4or 5+) Foundry Machine Operator other 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Health and Mental em 27 is marked o Martin George Herbert Mary Hynes 2 19e. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health a Important: If Nem 27 la any injury or other tra-Frank Powell 5110 Frye Road, Boring Maryland 21020 20b. Place of Disposition (Name of cematary, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriai 2 Cramation 3 Ramoval from Stata Woodlawn Cemetery 2/12 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funarai Service Licenses 22. Nama and Address of Facility
Burgee-Henss Funeral Home complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. 3631 Falls Road, Baltimore, Maryland Approximate Interval Batween Onsat and Death dugent **Physician** /Medical Immadiate Cause (Final disaasa or condition rasulting in death) Examiner Qua to (or as a consequence of): Examiner The law requires that the deeth certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequanca of): Division of Vital Records, P.O. Box 68760, physician Physician/Medicai the Dua to (or as a consequence of) ettending i signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Ca okon à 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 1 Yes 2 PINO 1 ☐ Yas 2 ☐ No Rhysicisn: Be 25. Was casa rafarrad to medical axeminar? 28. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how Injury occurred 5 Pending invastigation 1 PNeturai 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suicida 8 Could not be datarminad 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 6 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. within 24 hou To the Funer completely fil Medicai 29a. Cartifier To the 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Daia signed (Month, Day, Yaar) 23015 196 an 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) washington Hts. WESTMIAS S.KALARIA MO 217

State Registrar 31. Dete filed (Month, Day, Year) FEB 1 4 1996 32. Registrar's Signature

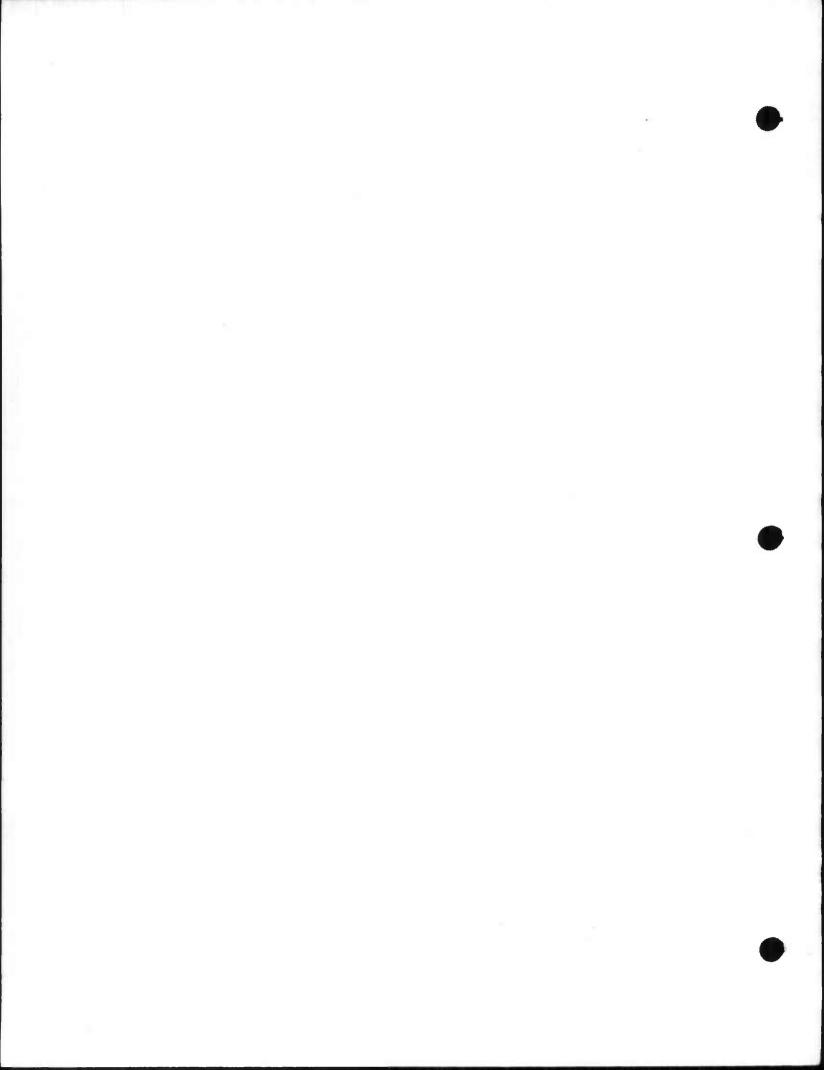
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be limit with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | nedis i nan | | | EHIIF | CALE | F DEATH | REG. NO | D. | |
|----------------------|---|--|--|-------------------|-----------------------------|--------------------------------|---|-----------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last | MASSI | In | ez V: | ictoria | Massey | 2. DATE OF DEATH | 96°, | YEAR 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | | | | | | 7 / | 796 |
| | 217-20-5004 | 1 □ M 2 🂢 F | 6. AGE (In yrs. las | YRS. | MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) | 1005 | 8. BIRTHPLACE (State or Foreign Country) |
| | 9e. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY, TOV | N OR LOCATION OF D | | 1905 9c. cou | South Carolina |
| DIRECTOR | Pikesville Conv | alesant (| enter | | P: | kesville | | | Baltimore |
| EC | 10a. STATE 10b. COUN | 400 | | 10c. CIT | Y, TOWN OR LO | CATION | | | 10d. INSIDE CITY |
| | Maryland | n/a | | | Cat | onsville | | | LIMITS? |
| 3AL | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | 10g. CIT | IZEN OF WHAT COUNTRY? |
| FUNERAL | 6005 Healy Farm | | | | | 21228 | | | USA |
| | 1 Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 2 | NO | If yes | specify Cuban, Maxic | NIC ORIGIN? (Specify Years, Puerto Rican, etc.) | n or No— | 14. RACE — American Indien, Black, White, atc. |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE V | MR OR DATES | | ' | rES 2 X NO Speci | fy: | | Specify: Black |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grad | UCATION le completed) | 16a. DE | CEDENT'S | USUAL OCCUP | ATION most of working | 16b. KIND OF B | JSINESS/IND | DUSTRY |
| H. | Elementary/Secondary (0-12) 6th Grade | College (1-4 or 5 | , | | | | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | COOK- | -Baker | 18. MOTHER'S N | Priv. AME (First, Middle, Maide) | | amilies |
| BE C | Preston Funderb | urke | | | | | CCloud | , ourname, | |
| 0 B | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS (Stre | | Route Number, City or To | vn, State, Zip | 21228 |
| - | Paulette Long | | | | | arm Road | Caton | svill | e, Maryland |
| | 20a. METHOD OF DISPOSITION 12 Burial 2 Cremation 3 Ref 4 Donation 5 Other (Specify) | noval from State | cemetery, cre | metory or of | F DISPOSITION har place) | - | | | City or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | Arbut | us Me | 22. NAM | Park AND ADDRESS OF F | Feb 14 Ba | Ltimo | re County, MD ral Homes, Inc. |
| | > Levi | Harken | | | 2001 | GMAITIN | alls Park | <i>N</i> a y | ral Homes, Inc. |
| | 23. PART I. Enter the diseases, or ehock, or heart fallure | complications that | caused the de | eth. Do n | ot enter the | mode of dying, suc | ch as cardiec or real | olratory an | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | | 1. | 11 | 2 | | Onset and Death |
| | reaulting in death) | a. NE | Maj | 1-an | une | (can | onio) | | >/year |
| _ | | D. | abete | SUENCE OF | Moll | (chi | | | |
| 임 | Sequentially list conditions, if any, leading to immediate | | (OR AS A CONSEC | | | | | | |
| S | CAUSE (Disease or Injury | c | (OR AS A CONSE | TIENCE OF | 1. | | | | |
| EDICAL CERTIFICATION | that initiated events resulting in deeth) LAST | 4 | (011 20 2 001102) | JOENOL OF | ,- | | | | |
| 2 | PART II. Other algnificent condition | ns contributing to | death but not - | a a vilida a d | | | | | |
| CAL | STROKE | tie contributing to | death but not r | econting i | ii the ungeri | ing cause given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| | CORUNDAL | 7 1054 E | FICIE | NC | 4 | | 1 TES | 2 DINO | OF DEATH? |
| N N | DID TOBACCO USE CON | | | | | ☐ UNCERTAI | N IZ | | 1 TES 2 NO |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | $\overline{}$ | H (Check only o | | | | |
| YSI | 1 TES 2 D NO | 1 - Inpatient 2 - | | □ DOA | OTHER: | ome 5 🗆 Rasidence | 6 Other (Specify) | | |
| ВУ РН | 27. MANNER OF GEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF (Month, D | | 28b. TIME INJU | JRY | INJURY AT WORK? YES 2 NO | 28d. DEŞCRIBE HOW | INJURY OC | CURED |
| a | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE O building, | F INJURY — At ho | me, ferm, s | treet, factory, o | ffice | 28t. LOCATION (Street City or Town, State | end Number | or Rural Route Number, |
| COMPLET | 290. CERTIFIER (Check only | SICIAN: To the best of | my knowledge, de | ath occurre | d at the lime, o | ate and place, and due | lo the cause(a) and me | Oner as stat | ed. |
| NO. | | | | | | | | | e ceuse(s) end menner es stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIE | P / | 11 | | n a A | 29c. LICENSE NU | MBER | 29d. DAT | E SIGNED (Month, Day, Year) |
| | 10/2 2 20 | 2 | C/A | | | | / | | |
| 띪 | 20 NAME AND ADDRESS OF PERSON WI | HO COMPLETED CALLS | E OF DEATH (ITE | W 271 /Time | Print) | 0158 | 12 | 1 | ch 9 1996 |
| TO BE | AND ADDRESS OF PERSON WITH | HO COMPLETED CAUS | E OF DEATH (ITER | | | HEIGHT | 5 21 | 200 | eh 9 1996 F |
| TO BE | | 30B . | E OF DEATH (ITEE 7 ZZO R'S SIGNATURE LICH AND AND AND AND AND AND AND AND AND AND | 81 | | HEIGHT | J 21 | 200 | ep 9 1996 8 |



| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | | TMENT OF H | | MENTAL HYGIE | NE |) (| 3330 |
|--------------------|--|---|---------------------------------|---|---------------------|---|----------------------|--------------------------------------|---|
| | DECEDENT'S NAME (First, Middle, Last) MARY | VERONICA | MCI | VALLY | | 2. DATE OF DEATH | DAY Y | 7EAR 3. 1 | 8:38 am |
| | 4. SOCIAL SECURITY NUMBER | | rrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | | CE (State or Foreign |
| | 216-52-7302 9a. FACILITY NAME (If not institution, give s | 1 M 2 F 83 | YRS. | MONTHS DAYS | HOURS MIN. | Jan. 13, | 1913 | Mary | |
| OR | Saint Joseph Med | | | | vaon, Mar | | | altimor | |
| 2 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | · · · · · · · · · · · · · · · · · · · | the CIT | , TOWN DR LOCA | TION | | | 104 | I. INSIDE CITY |
| DIRECTOR | | Baltimore | | Towso | | | | | LIMITS? YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 2300 Dulaney Val | ley Road | | 10 | 2120 | 4 | 10g. CITIZEI | N OF WHAT | COUNTRY? |
| BY FUNI | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN U FDRCES? 1 YES IF YES, GIVE WAR OR DATE | 2 NO | If yes, sp | | NIC ORIGIN? (Specify Y in, Puarto Rican, etc.) y: | ae or No— 14 | I. RACE — / Black, Wh Specify: | |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION 16 | Be. DECEDENT'S | USUAL OCCUPATION | DN | 16b. KIND OF B | USINESS/INDUS | TRY | White |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | rork done during mo e retired.) naker | st or working | | 4. 1 | | 900 |
| OMI | 17. FATHER'S NAME (First, Middle, Last) | | nomer | naker | 16. MOTHER'S NA | AME (First, Middle, Maide | t home | | |
| BEC | Peter J. Ritter | | | | Katheri | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Mr. L. Bradley M | cNally (Son) | | | and Number or Rurel | Aoute Number, City or To | | | 19382 |
| | 20a. METHOD OF DISPOSITION | 20b. PL | LACE AND DATE O | F DISPOSITION /N | | | OCATION - CIT | | |
| | 1 X Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | Mor | ry, cremetory or ot celand N | 1emorial | | /12/96 B | altimor | ce Ma | ryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | Luck | | | owson Fu | сштү neral Hom | e, Inc. | . 105 | 0 York Rd |
| | 23. PART I. Enter the diseases, or shock, pr haert failure. IMMEDIATE CAUSE (Final disease pr condition resulting in daath) | compilections that caused the List only one cause on section ACUTE MYO | h line. | | | h as cardlec or ras | piratory arres | t, | Approximate Interval Batween Onset and Death DAY |
| | readiting in death) | DUE TO (OR AS A CO | ONSEQUENCE OF |): | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (DR AS A CO | ONSEDUENCE DE | 7): | | | | | YRS. |
| | | d | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other eignificent condition | | | | | PERF | AN AUTOPSY ORMED? | AVA COI DF | RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION DF CAUSE DEATH? YES 2 |
| AN: | DID TOBACCO USE CONT | | | S NO | UNCERTAI | N 🗆 | | | |
| SICI | EXAMINER? | HOSPITAL: | | OTHER: | s 5 Pasidance | 6 Other (Specify) | | | |
| ЭНХ | 27. MANNER OF DEATH | 28a. DATE DF INJURY (Month, Day, Year) | 28b. TIMI | E OF 28c. IN. | URY AT | 26d. DESCRIBE HOW | INJURY OCCU | RED | |
| ВУ | 1 Seturel 5 Pending 2 Accident investigation | | | M 1 🗆 | YES 2 ND | | | | |
| | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, a | treet, factory, offic | • | 261. LOCATION (Stree City or Town, Star | | Aural Route | Number, |
| COMPLET | | ICIAN: To the best of my knowled | | | | | | | d manner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIED | int Ricem M | 9 | | 29c. LICENSE NU | | | SIGNED (Moi | nth, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEATH | | * | | | | | 7 |
| | RICHARD L. LINTH | AT DECIETATION CICHATO | | MEDIC/ | AL CTR., T | OWSON, ME |). 21204\ | | |
| | 31. PATE FILED (Month, Day, Year) FEB 1 4 1996 | Fulia Davidson-Para | 200 | | | | | | |



| TINDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should | affine death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|---|
| THE HOSPITAL ATTENDING PHYSICIA | THE FUNERAL DIRECTOR: After this certi- | filed within 72 men all the death with the | IPORTANT: If item 28 is marked, or |

| 1. DECEDENT'S NAME (First, A | Middle, Last) | | | | | | | 2. DATE | OF DEATH | v | WEAT | 3. TIME OF DEAT | Н |
|--|---|--|--|--|--|--|--|--|---|--|-----------------------------|--|---|
| Marga | aret | Mary | Mooi | re | | | | Febru | | | YEAR 1996 | 5:30 |) p' |
| 4. SOCIAL SECURITY NUMBER 220-48-9691 | R S | S. SEX | 8. AGE (In | yrs. last birthday | IF UNDER | R 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (| F BIRTH Day, Year) | | S. BIRTH Count | IPLACE (State or Fo | reign |
| 213 03 9991 | | 1 M 2 X F | | 91 YRS. | MONTHS | UM78 | moons min. | | ry 4, 1 | 905 | | ryland | |
| 9a. FACILITY NAME (If not insti | nor N | et and number) ursing | Hom | e | 77,24 | | more | EATH | | 9c. COUN | N/A | | |
| RESIDENCE OF DECE | 10b. COUNTY | | | 10c. CI | ITY, TOWN (| OR LOCATI | ON | | | | | 10d. INSIDE CITY | , |
| Maryland | | N/A | | | Bali | timo | re | | | | | LIMITS? | NO |
| 10e. STREET AND NUMBER | | | | | | 7 | ZIP CODE | | | 10g. CITI | ZEN OF | WHAT COUNTRY? | |
| 1500 E. | | | | | | | 21218 | | | | ited | State | S |
| 11. MARITAL STATUS 1 Never Married 2 M 3 Widowed 4 Divorce | farried | FORCES? IF YES, GIVE | YES | 2 X ND | | H yes, spe 1 YES | ENDENT OF HISPA celty Cuban, Maxico 2 X NO Specia | n, Puerto R | ? (Specify Yes ican, atc.) | or No— | 14. RACI Blac Spec | E — American Indi k, Whita, etc. #y: Whi | |
| | DENT'S EDUCA | | T | 16a. DECEDENT | 'S USUAL O | OCCUPATIO | N et of working | 16b. | KIND OF BUS | SINESS/IND | USTRY | | |
| Elementary/Secondary (0-1 | | College (1-4 or 5 | +) | (Give kind o life. Do NOT | | | t or working | | | | | | |
| 10 | fello d auth | | | Homem | naker | r | | | Own | | | | |
| John Lo | | | | | | | 18. MOTHER'S NA | WHE (First, A | nddle, Maiden | Sumame) | | | |
| 19a. INFORMANT'S NAME (Typ | | | | 19b. MAILIN | NG ADDRES | SS (Street ar | nd Number or Rural | Route Numb | er, City or Town | n, State, Zip | Code) | - 11 | _ |
| Mrs. Helen P | eters | | | 171 | 7 Kur | tz A | venue | Luti | nervil | le, l | Md. | 21093 | |
| 20a. METHOD OF DISPOSITION t X Burial 2 Cremation 4 Donation 5 Other (5 | 3 Ramov | ral from Stata | ceme | PLACE AND DATE stery, crematory or tholy R | other place) | 1) | | 2/12/9 | | CATION - | | own, State Marylar | d |
| 21. SIGNATURE OF FUNERAL | SERVICE LICE | NSEE Mar | _ | PE INTA V | | | | | J Da | | JIE. | rial y lai | |
| 14-4 0 | | | KI. | 7avovr | na 22. | . NAME AN | D ADDRESS DF FA | CILITY | | | | | |
| 23. PART I. Enter the disahock, or har IMMEDIATE CAUSE (Fina disease or condition resulting in desth) | art feilure. Li | augua | at caused | the death. Do | Id | Leo: | nard J. 5 Harfo de of dylng, suc | Ruc ord F | Road lac or reapl | Bal ratory arr | est, | Approximintervsi B | 214 etwee |
| ahock, or had IMMEDIATE CAUSE (Final disease or condition | art feilure. Li ii a. b. ions, iote iG | mplications the set only one ca | of COR AS A | the death. Do | o not arried | Leo: | nard J. 5 Harfo de of dylng, suc | Ruc ord F | Road | Bal ratory arr | est, | Approxim | 214 ate |
| shock, or hai immediate cause immediate cause or condition resulting in deeth) Sequentially list condition if any, leading to immediate cause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events | art feilure. Li | mplications the strong one ca | et caused use on ee | the death. Do ch line. | onot ame | Leon 530 ser the moor | nard J. 5 Harf(de of dying, sue | Rucord For as cond | Road lac or reapl | Bal ratory arr | est, | Approxim | 214 ate etwee |
| shock, or hei IMMEDIATE CAUSE (Fine disesse or condition resulting in death) Sequentially list conditio if any, leading to immedi cause. Enter UNDERLYIN CAUSE (Disesse or injuri that initiated events resulting in death) LAST PART II. Other significen | ant feilure. Li a. b. cons, lete elG c. d. conditiona | mplications the strong one can but to | at caused use on ee | the death. Do ch line. | o not anier OF): OF): | Leon 530: The moore the mo | nard J. 5 Harfo de of dying, such 1 | Rucord Feth as card | Road lac or reapl August 24a. WAS AN PERFOR | Bal ratory arr | est, | Approximinterval B Onset an Onset an b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION OF | 214 ate etwee of Deat |
| shock, or hei iMMEDIATE CAUSE (Fine disease or condition resulting in deeth) Sequentially list conditio if any, leading to immedi cause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST | ant feilure. Li a. b. cons, lete elG c. d. conditiona | mplications the strong one can but to | at caused use on ee | the death. Do ch line. | OF): OF): YES | Leo 530: Inderlying | nard J. 5 Harf(de of dying, sue | Rucord Feth as card | Road lac or reapl August 24a. WAS AN PERFOR | Bal ratory arr | est, | Approximinterval B Onset an Onset an b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION OF DF DEATH? | 214 ate etweeth di Deat |
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| ahock, or hei IMMEDIATE CAUSE (Fine disease or condition resulting in death) Sequentially list conditio If any, leading to immedi cause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significen DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NND 27. MANNER OF DEATH | ant feilure. Li ii a. b. iiete elig y d. d. MEDICAL | DUE TO | at caused use on ee | CONSEQUENCE CONSEQUENCE TO DEATH 28. PLACE OF DE without 3 □ DOA 28b. T | OF): | Leon 530: str the moore the moore than the moore that the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore than the moore that the moore th | Hard J. Harf(de of dying, such ceuse given in UNCERTAL S = Rasidence | Part i. | 24a. WAS AN PERFOR | AUTOPSY RMED? | 241 | Approximinterval B Onset an Onset an b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION OF DF DEATH? | 214 ate etweet 1 Deat in Direction To CAUSE |
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| ahock, or hai immediates or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter UNDERLYIN CAUSE (Disease or injurt that initiated events resulting in death) LAST PART II. Other significen DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural 5 P P ACIDENT STAND 2 Accident S G G G G G G G G G G G G G G G G G G | ant feilure. Li a. a. b. cons, lete elG y d. conditiona SE CONTRI MEDICAL Pending investigation could not be letarmined FYING PHYSICI CAL EXAMINER | DUE TO | AUSE OF INJURY Day, Year) Of INJURY (Special Control of my knowledge) | the death. Do ch line. CONSEQUENCE CONSEQUENCE CONSEQUENCE It not resulting PLACE OF DE Relation 3 DOA 28b. T At home, tarm Ry) | OF): OF): OF): OF): YES ATH (Check ATH (Check NJURY) IMEOF NJURY IMEOF NJUR | Leon 530: string moderlying NO k only one) ER: uraing Hom 28c, INJ t T tectory, office | Hard J. Harf(de of dying, such ceuse given in UNCERTAL S Rasidence URY AT RK7 RS 2 ND and place, and du | Rucord F the accord of F the accord of F the accord of F the accord of F the accord of F the accord of F the accord of F the accord of T the a | 24a. WAS AN PERFOR 1 YES 2 | AUTOPSY MED? NO NJURY OCCUPANT AND AUTOPSY MACON NO NJURY OCCUPANT AND AUTOPSY MACON NO NJURY OCCUPANT AND AUTOPSY NO N | 24II CURED or Rural ted. | Approximinterval B Onset an Onset an D. WERE AUTOPSY F AMALABLE PRIOR COMPLETION OF DF DEATH? 1 YES 2 Route Number. | 214 are etwee of Death mindings To cause No |
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State of Maryland / Department of Health and Mental Hygiene 9 6

03932

Certificate of Death ITEM#1 film q732 2/14/96 ag per FH 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** RICARDON NELSON DWIGHT RICHARDO NELSON DWIGHT 1996 0840AM FEB. /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** OLD ROBIN HOOD ROAD HAVEDE GRACE HARFORD If Under 24 Hrs. Hours Min. If Under 1 Yeer Dete of Birth (Month, Dey, Year) JAN. 25, 1967 5. Scciei Security Number 7. Age (In yrs. lest birthdey) 9. Birthpiece (State or Foreign **Funeral** 10 M 20 F Months Deys JAMATCA 29 unk. Yrs. Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits x 28a-f show 1XXVes 2 No **BROOKLYN** Director MD n/a 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES with h and Mental Hygiene. 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examinar markes. 168 - 15116 TH AE. unk, Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 Is merked other than "natural", or items 23.
Iny or other traumatic event, the Madical Examinar number. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Sfetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Naver Married XX Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 1□Yes 2XXNo Specify: JAMAICAN þ Specify: BLACK 3 Widowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collage (1-4or 5+) LABORER various trades th 17. Fether's Neme (First, Middle, Last)
MARTIN NELSON 18. Mother's Neme (First, Middle, Meiden Sumeme) Be DOROTHY GORDON NELSON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ST, BALTIMORE, MD GAYLAND PORTER MONTEPELIAR 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Sfete Department of Important: If any injury or FLORIDA SUNSET MEMORIAL PARK 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility WM. C. MARCH FH.-1101 E. NORTH the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Part1. Enter the disease, or comp shock, or heart failure. List only of Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Wounds bunshot Examiner Dua to (or as a consequence of): Examiner Attending Physician: The lew requires that the death certificate be executed burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enfer Underlying Ceuse (Disaase or injury that initieted evants resulting in death) Lesf and Due to (or es a consequence of) physician : Box 68760, Physician/Medical Due to (or es e consequenca of) 88 for use signed by the a d be detached f P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy peed has page 2 certificate NZYes 2□No 1 Yes 2 No director 25. Wes casa referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) ROADWAY Certification: To 1X Yes 2 No this 28a. Dete of Injury
(Month Dey Year)
2 - \$ - 9 (funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Formul 1 Natural 5 Pending 546 ect shot 281. Location (Street and Number or Rural Route Number, City or Town, State) Old Robin Hos & Kol after death. 1 Yes 2 100 investigetion 6:05 AM 2 Accident 8 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) in by 4 Homicide Harford Co., Md street Funerel 1 Certifying Physician: To the best of my knowledga, daeth occurred at tha time, dete end pleca, end due to tha cause(s) end mannar as steted.

2 Padical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) end menner steted. 29a. Certifier Medical phetaly (Check only one) To the within 2 To the 29c. License number 29b. Signeture end fittle of cegifier 29d. Dete signed (Month, Day, Year) FEBRUARY 9, 1996 Chute and O.C.M.E 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Chute mo Dennis 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

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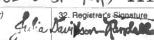
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| treumatic e | 5 | Johnnie B. Owens Polly Booth 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Ste | | | | | | | | |
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| other | | 20e. Method of Disposition | | 20b. Place of | Disposition (Name of y, cramatory or other p | | Date | 20c. Location | | |
| ant: If item 27 lury or other 1 | | 1 ☑ Burfai 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | | iseland Ba | | 2/17/96 | Amelia | County | , Va |
| 2.2 | 23 62 | 21. Signature of Funeral Service Li | censee | | | | | | | |
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29c. Licansa number O.C.M.E. 29d. Data signed (Month, Day, Year) FEB. 12, 1996

oled gause of delin (tem 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 30. Nema and address of person who comprise MARIO F. GOLW

31. Date filed (Month, Dey, Year)
-EB 1 4 1996 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03934

| | | | | | | Certific | cate of | Death | | Reg. No. | 03 | 334 | | |
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| | Maryland and show | tor | 10a. Stata 10b. County Maryland Baltim | ore City | 10c. City, Tow Balt | n or Location CIMORE | | | | | 10d. la X | nsida City Limits | | |
| | 23a or 28 | Funeral Director | 10e. Straat and Number 6413 Fernbank Av | enue | | 10 | Zip Coda 2121 | 4 | | 10g. Citizan of V USA | /hat Country? | | | |
| 020 | be filed within 72 hours effer death with the Maryland tel Hyglene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examines must be negled | by Fune | 11. Marital Status 1 □ Never Merried 2 □ Married X Wildowed 4 □ Divorced | 12. Was Dacedant E Armed Forces? 1 ☐ Yas 2 ☐ N If Yas, Giva Yaar or Datas: | | | eacedant of I specify Cub as 2 No | | Specify Yas or No rto Rican, atc.) | 14. Race Blace Specify | e - Amaricen In k, Whita, atc. White | | | |
| 21215-0020 | within 72 he lene. then "netur | Completed by | 15. Decedant's Ec (Specify only highast gra Elamantary/Secondary (0-12) | | | Decedant's (Giva kind of lifa. DO No. | Usual Occu of work dona OT usa retire annie | pation during most of word) | orking | 16b. Kind of Bu | sinass/Industry | | | |
| and 2 | be filed itel Hygid d other event, u | Be | 17. Fathar's Nama (First, Middla, Last) David F. Leopold | | | | | 18. Mothar's Na Carol | ama (First Middle, ine A. B | Maldan Sumam | a) | | | |
| Maryland | 2 8 5 8 | To | 19a. Informant's Name/Raiationship (| Type, Print) | 195 | | | | Rural Routa Numbe le, Balt | | | | | |
| Baltimore, | Pages 1 end nent of Health ant: If item 27 ury or other to | | 20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 1 Other (Specific | Ramoval from Stata | 20b. Placa of cemata. Pleasa | f Disposition ny, cramaton nt Gro | (Nama of or other pla ove Ce | emetery | 2/9 | 20c. Location - Upperco | | | | |
| Balt | permit. Page: Depertment of Important: If i any injury or 20029. | | 21. Signature of uneral Sarvice Licensea 22. Nama and Addrass of Facility Burgee—Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland | | | | | | | | | | | |
| | 15/19 | | 23a. Partit Enter the disease, or compshock, or have failura. List only | plications that ceused tona causa on aach line | tha daath. Do | not antar tha | moda of dy | ng, such as cardie | ac or raspiretory as | rast, | App | roximate rvel Between | | |
| | Physician /Medicai Examiner | | Immadiata Causa (Final disaasa or condition rasulting in death) | | TIVE HE | | | | | | | at and Death | | |
| | | er | The state of the s | | Dua to (or as a | consequance | of): | | | | | | | |
| , | icate be executed physician and s the burial-transit | Examiner | Sequantially list conditions, if any, leading to immediate ceusa. Entar Undarlying Causa (Disaasa or injury that infliated avants | b | of): | | | 1 | | | | | | |
| 68760, | E 01 48 | Physician/Medical | Causa (Disaasa or injury that initiated avants rasulting in death) Last | c | Dua to (or as a consequence of): | | | | | | 1 | | | |
| Вох | 8 5 8 | an | | d | | | | | | | | | | |
| 0. | 0 0 2 | /sici | Pert II. Other significant conditions of | ontributing to death but | not rasulting in | n tha undariy | Ing ceusa gi | van in Part I | 23b. Dld 1 | obacco uss cor | tribute to the | cause of death? | | |
| 0 | res that the de signed by the a d be detached to | by | | | | | | | 10 | Yes 2□ No | 3 Probably | Unknown | | |
| Records, | need peen should | Completed | | | | | | | 24a. Was perfo | an autopsy med? | evallabl | utopsy findings a prior to tion of ceuse n? | | |
| alF | | | | | | | | | 101 | es spino | 1 🗆 Yes | 213 No | | |
| Vital | Physicien: The this certificate ral director, per | Be | 25. Was case referred to medical examiner? | Hospital: | 1 | and the same of the same | Ot | hor / | eath (Check only o | | Charles and a | | | |
| 7 | Phys r this aral di | 1: 70 | 1 Yes 2 No 27. Manner of Death | 1 Inpatien 28g. Date of Injury | 28b. 7 | tpatient 3t. Time of | 28c. Inju | 4 LE Nursing | Home 5 Resid | now injury occurr | | | | |
| 3jon | After After a funer | ation | 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | Year) I | njury M | | rk? Yes 2∐No | | | | | | |
| Divig | To the Hospital Autonoling P within 24 hours efter death. To the Funeral Director: After t completely filled in by the funers | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 88. Place of Injur building, etc. | y - At home, fa (Specify) | rm, street, fa | ctory, office | | 28f. Location (S City or Tox | Street and Number, State) | er or Rural Rou | te Number, | | |
| - | n 24 hour n 24 hour ne Funer pletely fill | edicai | 29a. Certifier (Check only one) (Check only one) | reician: To the best of iner: On the basis of a and manner state | examination as | deaffraccu | rred at the ti | me, date and plac opinion, death occ | e, and due to the urred at the time, | seuse(s) and ma date and place, s | nner as stated. and due to the | cause(s) | | |
| | To th To th | X | 29b. Signature and title of certifier | | | | 29c. Lighty | se number | 4 | 29d. Date signed | | Year) | | |
| | 6 | | • | | | | // | - > - 1 | C: | 2.9 | 72 | | | |
| | 40 | | 30. Name and address of person who o | | | | | | 0000 0.0000 | | | | | |
| | | | EDDIE NAKHUDA, 1 31. Date filed (Month, Day, Year) | M.D. 2300 | DULANE | Y VALI | EY RD | . TOWSO | N, MD 21 | 204 | | | | |
| | Sta | te | FFR 1 4 1996 | 32. Registrar | Kerlell | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 9 5 0 3 9 3 5

| | 4 | | Certificate of Death Reg. No. | | | | | | | | | | | |
|--------------------------|--|----------------|--|------------------------------------|---------------------|---|-------------------|---|--|--------------------------------|--|--|--|--|
| B | D1 | | 1. Decedent's Neme (First, Mide | fle, Last) | | | | | 2. Dete of Deet | | Venz | 3. Time of Deeth | | |
| J | Physici /Medi | | MUNYA ANDREA PA | ANASUK | | | | | February | - | Year 1996 | 3:20 P.M. | | |
| | Exami | | 4e. Fecility Neme (If not institution | on, give street end number | er) | | | 4b. City, Town, or Lo | ocation of Deeth | 4c. County | | timore | | |
| Н | F | | Stella Maris 5. Social Security Number | 6. Sex 7. | Age (In yrs. last i | hirthdey) If Unde | r 1 Yeer | Towson If Under 24 Hrs. | 8 Date of Birth | | | | | |
| | Funerai Director | | 219–12–5020 Usuei Residence of Decedent | 1□ M 2 🕌 F | 71 | Yrs. Months | | Hours Min. | 8. Dete of Birth (Month, Dey, Dec 24 | 1924 | | plece (Stete or Foreign ntry) ryland | | |
| | ylend | | 10e. State 10b. Count | У | 10c. City, To | wn or Locetion | | | | | | 10d. Inside City Limits | | |
| | r 28a-f show | Director | | ward | | Ellicot | t Ci | .ty | | | | 1 ☐ Yes 2X No | | |
| | th with the 23a or 2 | rai Dire | 3359 D North | Chatam Roa | .d | 10f. Zi | p Code 21 | 042 | 10 | g. Citizen of U.S | Whet Cou | ntry? | | |
| 020 | a within 72 hours effer death with the Maryland ijone. Then "natural", or flems 23a or 28a-f show the Medical Examinet must be notified at | by Funerai | 11. Maritei Stetus 1 □ Never Merried 2 □ Ma 3 □ Widowed 4 ☒ Divorca | H Ves Give | s? XNo | | | dispanic Origin? (Spen, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | Rece - American Indien, Bieck, White, etc. Scify: White | | | |
| 21215-0020 | 72 hou natura | | 15. Decade | nt's Education | | a. Decedent's Usu | iei Occur | pation | | 6b. Kind of B | usiness/In | dustry | | |
| 121 | within 7 ene. than "r | Completed | Elementary/Secondery (0-12) | est grede completed) College (1-4c | or 5+) | | | during most of work d) | | | | | | |
| 42 | e filed w al Hygier other ti | | 12 17. Fether's Neme (First, Middle | (act) | | Claims A | agus | 18. Mother's Name | | | | rity Admin | | |
| an | 0 5 0 0 | To Be | Andrew Panasuk | | | | | Anna Bob | | eideri Sürriei | 110) | | | |
| Maryland | d 2 sh th end 7 is m traum | Ĺ | 19e. informent's Neme/Reletion Andrea Baridon | | | 9b. Meiling Addres | s (Street | and Number or Run ircle Whe | al Route Number, eaton, Ma | City or Town | Stete, Zij | 906 | | |
| Baltimore, | 8 = 6 | | 20e. Method of Disposition 1 | 3 Removei from Ste | | of Disposition (Ne tery, cremetory or Andrews C | | 14, 199 | | Oc. Location | | | | |
| alti | pemit. Pa Departmer Important: any injury | | 21. Signeture of Service | | 0 | 22. Neme e | nd Addre | ss of Fecility | | | | aryland | | |
| m | Deparimbon any ir | | Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Marylance 23e. Fartt. Enter the disease, or complications may caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximatint revail and the disease. Approximatint revail and the disease or complications may caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and | | | | | | | | | | | |
| | - | | 23e. Part L Enter the disease, of | r complication | sed the deeth. D | o not enter the mo | de of dyle | ng, such es cardiec | or respiretory arre | SVIIIE | e, Ma | Approximate Interval Between | | |
| đ | Physician | | | | | | | | | | i | Onset and Deeth | | |
| | /Medical Examiner | | Immediate Ceuse (Fine) disease or condition resulting in death) | . CAN | CERC | FPA | NC | REAS | | | 1 | mouth | | |
| | 100 | er | Control Persons | | Due to (or es | e consequenca of) | : | | | | | | | |
| | outed nd ransit | Examiner | Sequentially list conditions | b | Due to (or as | e consequence of) | : | | | - | | | | |
| 0 | e axec ian ar uriel-ti | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events | , | | , | | | | | | | | |
| 68760, | thet the death certificate be assouted ed by the ettending physician and detached for use as the buriet-transit | edicai | thet initiated events resulting in deeth) Lest | С. | Due to (or es | consequenca of): | : | | | | 1 | | | |
| - | ding p | | | d | | | | | | | | | | |
| Вох | death cer re ettendir ad for use | by Physician/N | | | | | | | 1 | Statistics and the | 1.04 | | | |
| 0 | the d | hysi | Part II. Other significant conditi | _ | _ | | cause giv | en in Pert I. | 23b. Did to | | | o the causs of death? bably 4 □ Unknown | | |
| S, D | signed I | Dy P | Cerebrovas | scular | Teras | WT | _ | | | 2900 | 00110 | oubly 4 official | | |
| cord | peed shou | Completed | th/o Hype | ocular P ntension | 2 | | - | | 24e. Wes ar perform | autopsy ed? | av | ere autopsy findings alleble prior to empletion of cause death? | | |
| Ä | ysicien: The lew s certificate hes b director, page 2 s | mo | O | | | | | | 1□ Ye | s 20 No | 1[| ☐Yes 2 No | | |
| /ita | | Be | 25. Was case referred to medical examiner? | | | | | 28. Piece of Deet | h (Check only one |) | | | | |
| vision of Vital Records, | | 2 | 1 Yes 2 No 27. Menner of Deeth Neturel 5 Pendi | 19 | | | 28c. Injui Woi | ry et rk? | me 5 Reside 28d. Describe ho | | | y) Hospice | | |
| 18 | after death. Director: After | licat | 3 ☐ Suicide 6 ☐ Could | not be | Injuny - At home | M ferm, street, fector | | Yes 2 □ No | 28f. Location (Str | eet end Numi | her or Run | al Route Number | | |
| ā | e Pire | Certification: | 4 ☐ Homicide determ | nined 286. Pleca of building, | etc. (Specify) | 101111, 311001, 100101 | y, omos | | City or Town | | 001 01 1101 | | | |
| 7 | To the Hopping Managed Within 24 hours all the closely for the Funeral Director. After the completely filled in by the funeral | edicai C | 29a. Certifier (Check only one) Certifyi | ng Physician: To the besi | of exemination e | ge, deeth occurred and/or Investigetion | et the tir | me, dete and plece, opinion, deeth occurr | and due to the ca ed et the time, de | use(s) and mo te end piece, | enner as a and due t | tated. the cause(s) | | |
| | Within To the comp | Me | 29b. Signeture end title of cartific | er - C | | 29 | c. Licens | se number | 29 | d. Dete signe | d (Month, | Dey, Year) | | |
| | 1 | | Kenda | le Ra | ulka | ceus! | De | 2564 | 3 | 2/12 | 196 | | | |
| | 6 | | 30. Name and eddress of person | who completed cause o | f deeth (item 23e |) (Type, Print) | | | | | | | | |
| | | | DR. KENDALL FA | | | EY VALLE | Y RD | ., TOWSON | , MD 21 | 204 | | | | |
| | Sta Registr | | FFR1 A 1996 | 32. Regis | strer's Signeture | | | | | | | | | |

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egen, des al film e an ém, talike, l L'Al Fidure de les estepons que agua après a

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State of Maryland / Department of Health and Mental Hygiene

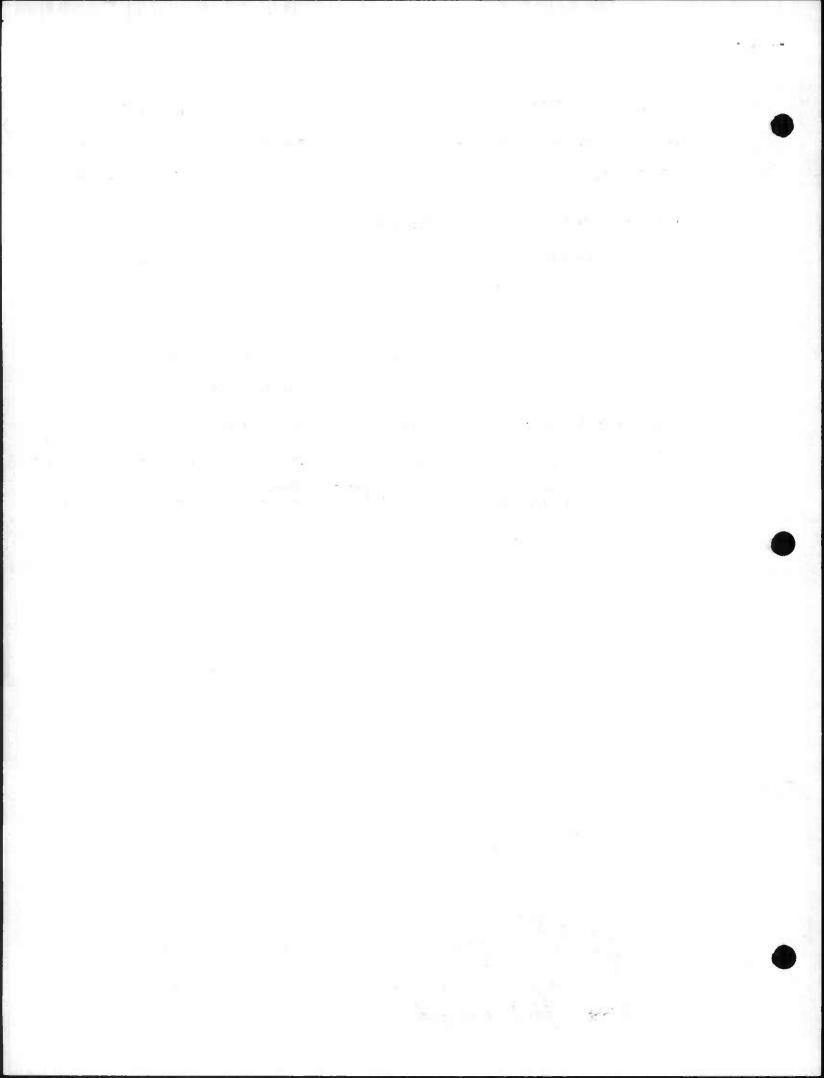
| Physici: | an | 1. Decadant's Name (First, Middla, Last | | | h | | 2. Deta of Deet Month | Day | Year | 3. Tima of Death | | | | |
|--|------------------|--|--|-------------------------------------|--------------------------------|---|---|------------------------------------|---|---|--|--|--|--|
| /Medic | | FRANCIS ' | MAR | K ! | PIEPER | | FEBRUAR | 1 700 | 1996 | 1-15 PM | | | | |
| Examin | er | 4a. Fecility Nama (If not institution, giva Good Samarita | | | | | ore City | 4c. County | N/ | | | | | |
| Funeral Director | | 5. Sociel Security Number 212-03-5719 6. Se | X 7. Aga XIM 2□F | (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | Hours Min. | 6. Data of Birth (Month, Day, Apr. 25 | 1914 | 9. Birthpiec Country | e (Steta or Foreign Maryland | | | | |
| M W | | 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d. | Inside City Limits | | | | |
| in Paris | ctor | Maryland | N/A | | | Baltimore | City | | | 1 X Yas 2 □ No | | | | |
| or 28 | Director | 10e. Street and Number | () | L. Common | 10f. Zip Coda | 04.006 | 10 | og. Citizan of | | | | | | |
| 23a | Funeral | 5/21 I | Newholme A | | Was Decedent of H | 21206 | acifu Vae or No. | United | o - Amarican | | | | | |
| *naturel", or items 23a or 28a-f ahow odical Examiner must be notified at | by | 1 Navar Marriad 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yas 2 X No if Yas, Giva Year or Dates: | 2 | ff Yas, specify Cube | dispanic Origin? (Sp an, Maxican, Puarto Specify: | Rican, atc.) | | ck, Whita, atc | | | | | |
| Hygiene. ther than "naturel", or items 23a or 28a-f ahow ent, the Medical Examiner must be notified at | eted | 15. Decedant's Edu (Specify only highest grad | ication | 18a. Dece | dant'a Usual Occup | pation during most of work | ina | 16b. Kind of B | usinass/Indus | try | | | | |
| iene. Than *natu The Wedical | Completed | Elementery/Secondary (0-12) | Collega (1-4or 5+ | ·) | | during most of work d) | | Г | airy | | | | | |
| tal Hygiene. d other than event, the M | | 17. Fathar's Name (First, Middla, Last) | | | Salesman | 18. Mother's Name | a (First, Middle, N | | | | | | | |
| | To Be | | Henry J. | Pieper | | N | lary L. V | Villing | ham | | | | | |
| and Mer is marks eumatic | | 19a. tnformant's Neme/Raiationship (7) | | | - | end Number or Run | | | | ode) | | | | |
| f Health fem 27 other tr | | Dorothy C. Pieper | r (Wife) | | | e Ave. Bal | | | 1206 | | | | | |
| 5= 5 | | 20e. Method of Disposition 1 🕱 €uriai 2 □ Cramation 3 □ F | | 20b. Plece of Dispo | | | | 20c. Location - | 111111111111111111111111111111111111111 | | | | | |
| | | 4 Donation 5 Other (Specify) 21. Signature of Funerei Service Licens | | 20000000000000 | Valley Me 2. Nama and Addra | emorial 2/ | | Timoni | | laryland | | | | |
| Departr Importa eny inju | |) W.O.A | 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 | | | | | | | | | | | |
| ing physician and e as the burial-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that intieted events resulting in death) Last | END S | DISEASE | | | 1, | MONTH | | | | | | |
| attending for use a | lan | | d | | | | | | | | | | | |
| ed by the detacher | y Physician/M | Part It. Other significant conditions cor | ntributing to death but | not resulting in the u | ndarlying causa giv | van in Part I. | | bacco use co | | e cause of death | | | | |
| has been signing 2 should be | Completed by | | | | | | 24a. Was ar perform | | availa | autopsy findings ble prior to letion of cause hth? | | | | |
| certificate has b | Com | | | | | | 1 □ Ya | s 200 No | 1 🗆 Y | as 2 No | | | | |
| s certificate director, pag | Be | 25. Was casa referred to medical axaminar? | Janaitali, a. P | | 0.11 | 28. Piaca of Deat | h (Check only on | a) | | | | | | |
| 0 TO | 2 | 1 ☐ Yes 28 No 27. Menner of Death | lospital: 1 Inpatien 28a. Data of tnjury | | | 4 LI Nursing Ho | rna 5 🗆 Rasida 28d. Dascribe ho | | | | | | | |
| : After | ation | 1 Natural 5 Panding investigation | (Month, Day | Year) Injury | Wor | rk? Yas 2 □ No | 200. 2000.00 110 | injury coods | .00 | | | | | |
| within 24 hours after count. To the Funeral Director: After the completely filled in by the funeral | Certification: | 3 Suicida 6 Could not be 4 Homicida datermined | 28a. Placa of Injur building, atc. | y - At homa, farm, str (Specify) | reet, factory, offica | | 28f. Location (St. City or Town | raat a <i>nd N</i> umb , Stete) | per or Rural R | oute Number, | | | | |
| 24 hours Funeral stely filled | edicai C | 29e. Certiflar (Check only one) Cartifying Physical Cartifying Ph | stclan: To the best of ner: On the basis of e and mannar state | examinetion and/or In ed. | vastigation, in my o | plinion, daath occur | red at tha tima, de | eta and place, | and dua to th | e causa(s) | | | | |
| C 2 6 | ž | 29b. Signatura end titla of contillor | | | 29c. Licans | a number | 25 | d. Data signe | d (Month, De | y, Year) | | | | |
| within To the comple | | | - 10 | | | | - | | | 4 | | | | |
| Volthin Comple | | Macri | on | MD | PC | MARITA | 5 # | EBRU | ARY, | 74 1996 | | | | |

State Registrar

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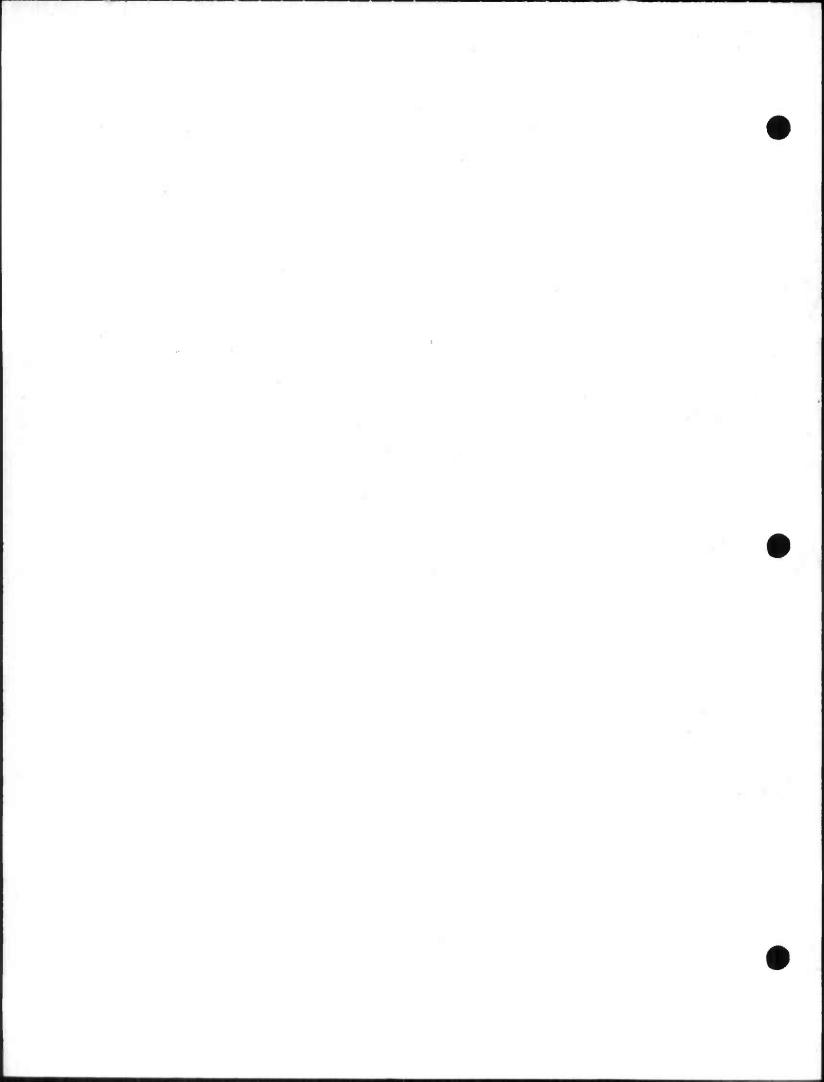
State of Maryland / Department of Health and Mental Hygiene 6 0 3 9 3 7

| _ | | | | | | Certifica | ate of | Death | | Reg. No. | 0 0 | 3931 |
|------------|--|------------------|---|--|--|--|------------------------|--|---|----------------------------------|--------------------------|--|
| п | Physic | ián | Decedent's Neme (First, Middle, La | • | | | | | 2. Dete of D Month | eeth Dev | Year | 3. Tree of Courth |
| J | /Medi | | Margaret Mary Pu | | | | | | Febru | ary 8, | 1996 | 3;10 P.N |
| O. | Exami | | 4e. Facility Name (If not institution, giv | e street and number, |) | | | 4b. City, Town, or | Location of Dea | th 4c. Cour | nty of Deeth | |
| | | | Holly Hill Manor | Nursing H | ome | | | Towsor |) | | Balt | imore |
| | Funerai | | 5. Sociel Security Number 6. S | ex 7. A | ge (In yrs. la | st birthdey) If Un | der 1 Year | If Under 24 Hr | s. 8. Dete of B | irth | | place (State or Foreign ntry) |
| ă(C | Director | | Usuel Residence of Decedent | □M 2ŪXF | 92 | Yrs. | 15 00/3 | 110013 | May 20 | ,1903 | Mary | yland |
| | yland mow | | 10e. Stete 10b. County | | 10c. City, | Town or Location | | | _ | | 1 | 10d. Inside City Limits |
| | ith the Marylan or 28a-f ahow | io | Maryland N/A | | Bai | ltimore | | | | | | 1 X Yes 2 □ No |
| | r 28 | je je | 10e. Street and Number | | | | Zip Code | | | 10g. Citizen o | Citizen of Whet Country? | |
| | th wit | Funeral Directo | 6401 Loch Raven B | lvd. | | | 21239 |) | | U.S | Α | |
| | Hems : | ner | 11. Meritel Stetus | 12. Wes Decedent | Ever in U,S | | | Hispanic Origin? (ben, Mexican, Pue | Specify Yes or N | | lece - Americ | |
| 21215-0020 | # 8 E | þ | 1 ☐ Never Married 2 ☐ Merried 3 ဩ Widowed 4 ☐ Divorced | Armed Forces: 1 Yes 2 X If Yes, Give Yeer or Detes: | | 1 | 2 X No | | rto Hican, etc.) | Spec | leck, White, cify: Wh | nite |
| 2-0 | 72 hours "natural", | Completed | 15. Decedent's Ed | | | 16e. Decedent's U | suel Occu | pation | det - | 16b. Kind of | | |
| 21 | within 7 ene. then "r | pe | (Specify only highest gra | College (1-4or | 5+) | 16e. Decedent's U (Give kind of life. DO NO? | use retire | auning most of wo ad) | orking | | | |
| | Hygien ther the | 00 | 8 | | | Home Ma | ker | | | 0wn | Home | |
| Maryland | 0 = 0 5 | Be | 17. Fether's Neme (First, Middle, Last) | | | | | 18. Mother's Ne | eme (First, Middle | e, Maiden Sum | eme) | |
| yla | should be ind Menta marked | 2 | Andrew Geraghty | | | | | Mary | Moyl | an | | |
| lan | and and | | 19a. Informant's Neme/Reletionship (| Type, Print) | | 19b. Meiling Addre | ess (Stree | t end Number or F | Rurai Route Numi | ber, City or Tow | vn, State, Zip | Code) |
| | 12 E | | Mrs. Teresa A. Ha | nsen | | 12417 S | andal | Lane , | Bowie , | Md. 20 | 715 | |
| ore | of Heal of Heal fitem 2 r other | | 20a. Method of Disposition | | COL | ece of Disposition (fi | Verne of | | Dete | 20c. Locatio | | own, State |
| Ĕ | | | 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetlon 5 ☐ Other (Special) | | New | Cathedra | l Cem | netery 2 | /12/96 | Baltim | ore. | Maryland |
| Baltimore, | permit. Pag Department Important: I any Injury c once. | | 21. Signature of Funerel Service Licen | 900/// | | 22, Neme Leoi | end Addre | ess of Facility J. Ruck | Funeral | Home, | Inc. | |
| | | | Umald Geli | efu fe. | | 530 | 5 Har | ford Roa | d - Bal | timore. | Maryl | land 21214 |
| | Physician /Medical Examiner | | 23a. Pent 1. Enter the disease, or companies, or heert fellure. List only disease or condition resulting in deeth) | e. Cere | brou | docular as a consequence of | A | | | | - (| Intervel Between Onset end Deeth |
| c 68760, | rtificate be executed ng physician and as the burial-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that included events resulting in death) Last | 0. | Due to (or a | | | | | | | |
| Box | death cert e ettendin ed for use | Physician/ | - | d | | | | | | | | |
| | he et fe | sic | Part II. Other significant conditions of | ontributing to death b | ut not result | ing in the underlying | cause gi | ven in Part I. | 23b. Did | tobacco use o | contribute to | the cause of death? |
| 0. | that the de led by the e detached t | | | | | | | | 10 | Yes 2ELNO | 3 □ Prof | bably 4 Unknown |
| Records, | law requires has been sign pe 2 should be | Completed by | | | | | | | perf | s an autopsy ormed? | oo of | ere autopsy findings allable prior to impletion of cause death? |
| Maj | | | 25. Was case referred to medical | | | | | DO Diversel De | | | 11. | ☐Yes 2☐ No |
| - | | o Be | examiner? | Hospital: 1 Inpatie | an after | R/Outpatient 3 1 | ou Ot | har | ath (Check only | 100 | and the second | CAL C |
| onlot | After the function | tion: To | 27. Manner of Death 1 Benatural 5 ☐ Pending | 28a. Date of Inju (Month, Da | ry 2 | R/Outpatient 3 (1) | 28c. Inju Wa | | Home 5 Res 28d Describe | how injury occ | | n |
| Division | i or Attending after death. Director: Afte d in by the fund | Certification: | 2 Accident avestigation 3 Suicide 6 Could not be determined | 286. Place of Inj | ury - At hom c. (Specify) | e, farm, street, fact | | 1100 0.02110 | 28f. Location City or To | (Street and Nur wn, State) | mber or Rura | al Route Number, |
| | To the Hospital within 24 hours a To the Funeral Completely filled | edical C | 29a. Certifier 1 Certifying Phy 2 Medical Exam | paician: To the best of the basis of menner st | f examinatio | edge, death occurre n and/or investigation | d at the tion, in my o | me, date and place opinion, death occ | e, and due to the urred at the time. | cause(s) and r date and place | manner as st | ated. the cause(s) |
| | Within 2 To the comple | Me | 29b. Signature and title of contribe | 1 | and the same of th | 13 | 9c Licens | se number | | 29d. Date sign | ned (Month | Day, Yearl |
| | F 3 F 8 | | 1 and | + V | lun | | | 17041 | | 9 Fes | | |
| | H | | 30. Neme and address of person who Marc I. Leavey M | | | 23a) (Type, Print) Drive - | Tows | on Max | vland 0 | 1204 | | |
| | Sta | ite | 31 Date filed (Month, Dev. Year) FEB 1 4 1996 | Registr | er's Signatu | m_ DITAG - | TOWS | ou , l'idr | ATOLIO S. | 1204 | | |
| | Registr | | FED 1 4 1996 3 | was well son | -Manda | 1550 | | | | | | |



| | Pages 1, 2, 3 should | | |
|-------------------------------------|---|----------------------------|---|
| HOSPITAL OF ALLERONING PROSPERATION | tached for use as the burial-transit permit, if | | once. |
| o may be retained by the | ctor, page 5 should be de | | te |
| INDIES ATTEN UTAGET, FAUS | ed in by the funeral dire | or removal. | medical examiner |
| to De executed within 24 | sician and completely fille | prior to burial, cremation | marked or item 23 shows any laiuty, or other traumatic event, the medical examiner must be notified |
| mar me heam cermina | has been signed by the attending phy | th and Mental Hygiene | any Injury, or other |
| MAN: THE IM TEQUIES | Tifficate | The State Dept. of Healt | or Item 23 shows |
| 7 | Uther this a | 1 | marked. |

| | 1 - FOR STATE REGISTRAR | OF MARYLAND / | DEPARTM ERTIFICA | | | MENTAL HYGI | | | | |
|---|---|---|------------------------------------|--------------------|---------------------|--------------------------------------|--------------------------|--------------|---|---------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 112 01 | DEATH | 2. DATE OF DEATH | 1 | | 3. TIME OF DE | ATH |
| | Howard Atwood | PH] | LLIPS | | | монтн February | 9, 199 | 96 | 11:05 | Рм |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 8. AGE (In yrs. le | | UNDER I YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Yea | | A | LACE (State or | Foreign |
| | 222-07-7862 1½ M 2 | 222-07-7862 152 M 2 G F 74 YRS. MONTHS DAYS HOURS MIN. Aug. 7, 1921 Ma: | | | | | | | | |
| 1 | 9e. FACILITY NAME (If not institution, give street and numi | | 9b. | CITY, TOWN O | R LOCATION OF DE | | | NTY OF DEA | | |
| DIRECTOR | Franklin Square Hospit | al | | Roseda | le | | Bal | timor | e Cour | ity |
| EC | 10a. STATE 10b. COUNTY | | 10c. CITY, TO | WN OR LOCAT | ON | | | | 10d. INSIDE CI | ry |
| 8 | Maryland Baltimore | County | Perry | . На11 | | | | | LIMITS? | OND |
| | 10e. STREET AND NUMBER | waitey | 1 retra | | ZIP CODE | | t0g. CITI | ZEN OF WH | AT COUNTRY | |
| FUNERAL | 9614 Dundawan Road | | | | 21236 | | U. | S.A. | | |
| 5 | | CEOENT EVER IN U.S. AT | | 13. WAS DECI | ENDENT OF HISPAN | HC ORIGIN? (Specify | Yes or No- | 14. RACE - | - American Inc | tian, |
| BY F | | GIVE WAR OR DATES | NO | | 2 NO Specify | n, Puarto Rican, etc. /: |) | Specify: | | |
| | 3 Wildowed 4 Divorced WWII | | | | | | | | WILLOS | |
| COMPLETED | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) | (0 | ECEDENT'S USU Give kind of work | done during mos | of working | 16b. KIND OF | BUSINESS/IND | DUSTRY | | |
| 2 | Elementary/Secondary (0-12) College (1-12th Grade | 4 or 5 +) [[3 | abor Re upervis | Tation | S | Rail | road | | | |
| NO | 17. FATHER'S NAME (First, Middle, Last) | 1. 50 | APCT VID | | 16. MOTHER'S NA | ME (First, Middle, Me | iden Surname) | | | |
| | Thomas Roland Phillips | | | | | Unknown | | V | | |
| BE (| 19a. INFORMANT'S NAME (Type/Print) | -19 | b. MAILING ADD | ORESS (Street a | | Route Number, City or | | - | | |
| 10 | Freda Lee Phillips | 9 | 9614 Du | ndawan | Road, B | altimore | , Mary | land | 21236 | |
| | 20a. METHOD OF OISPOSITION POXBuriel 2 Cremetion 3 Removal from St | 20b. PLACE | AND DATE OF DI | SPOSITION (Na | me of 2 /1 3 /9 | 6 DATE 200 | LOCATION - | | | |
| | 4 Donetion 6 Other (Specify) | Dular | iey val | Tey Me | morial P | ark T | imoniu | m, Ma | ryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 1 | | | Millow | | | | | |
| | Dathlein M. | Muzzh | 4/ | 6415 B | elair Ro | , Inc. ad, Balt | imore. | Mary | land 2 | 1206 |
| | 23. PART I. Enter the diseases, or complication shock, or heart fallure. List only or | na that coused the d | eath. Do not e | enter the mo | de of dying, suc | h as cardiec or r | espiratory an | rest, | Approxi | mata |
| | IMMEDIATE CAUSE (Finel | ie ceuse on eech in | 7 | | | | | | | Between nd Death |
| | disease or condition resulting in desth) a. Chronic anemia respiratory depression | | | | | | | | | |
| | | DUE TO (OR AS A CONSE | | | | | | | 7 mor | +40 |
| NO | Convention, list conditions | Prostate c | | | | | | | / 11101 | ILIIS |
| AT | If sny, leading to immediate cause. Enter UNDERLYING | DUE TO JUN AS A CONSE | OUENCE OF): | | | | | | | |
| 임 | CAUSE (Disease or Injury C. | DUE TO (OR AS A CONSE | OUENCE OF): | | | | | | - | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| | PART ii. Other significant conditions contribut | ing to dooth hut not | | no sum de alculare | January elizate la | man I an um | | 1.000 | | |
| CAL | PANT II. Other significant conditions contribut | ang to death but not | resulting in th | ne underlying | csuse given in | PEF | S AN AUTOPSY REORMED? | 1 | WERE AUTOPSY AVAILABLE PRIC COMPLETION OF | A TO |
| EDI | | | | | | T TYE | S 2 NO | | OF DEATH? | |
| Σ | DID TOBACCO USE CONTRIBUTE TO | O CALISE OF DE | ATH YES | D NO IX | UNCERTAIL | | | 1 | 1 YES 2 | NO NO |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | CE OF DEATH (C | | ONCERIAII | | | | | |
| SIC | EXAMINER? | AL: ont 2 DER/Outpatient | | THER: | a 5 □ Residence | 6 Other (Specify) | | | | |
| H | 27. MANNER OF DEATH 28a. D | ATE OF INJURY | 28b. TIME OF | 28c. INJ | URY AT | 26d. DESCRIBE H | OW INJURY OC | CURED | | |
| | t Natural 5 Pending 2 Accident Investigation | fonth, Day, Year) | INJURY | | RK? 'ES 2 NO | | | | | |
| 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) | | | | | | | | oute Number, | | |
| H | 4 Homicide determined | | | | | | | | | |
| PLE | 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the | best of my knowledge, d | leath occurred at | the time, date | and place, and due | to the cause(s) and | manner as ata | ted. | | |
| COMPLET | one) MEDICAL EXAMINER: On the be | sis of examination end/or | Investigation, in | n my opinion, d | eath occured at the | time, data and place | a, and dua to th | he cause(s) | and manner as | stated. |
| ш | 29L SIGNATURE AND TITLE OF CONTIFIER | -1 | | | 29c. LICENSE NUI | MBER | 29d. DAT | E SIGNED | Month, Pay, You | r) |
| TO B | * daming | das | | | RD 103 | 37 | ►× | 2/ | 7/96 | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLET | | | | mirro Dol | timoro M | arulan | d 212 | 37 | |
| | Dr Rohit Lakhanpal MD. 31. DATE FILED (Month, Day, Year) | | crin 2d | uare D | TIAE Dal | CIMOTE PI | aryrain | . 212 | J1 | |
| | FEB1 4 1996 | GISTRAR'S GNATURE | | | | | | | | |
| | LLUI I 1000 / | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TOTHE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYLANI | D / DEPARTM | | | MENTAL | HYGIEN REG. NO. | E | U | 03333 |
|------------------|--|---|--|---------------------|--------------------------------|--------------|--------------------|------------------|------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 0 | | | | OF DEATH | | | TIME OF DEATH |
| | Cora | Reynolds | | | | Janua | rv 24 | | RA | 3:45 P M |
| | 132-09-1848 | 10 M 2 SF 82 | YRS. MO | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE O | Day, Year) | 8. | BIRTHPL/ Country) DUTH | CATOlina |
| œ | 9e. FACILITY NAME (If not institution, give street | | | | LOCATION OF DE | EATH | | 9c. COUNTY | | |
| DIRECTOR | Maryland General I | Uspital | | Baltimo | re City | | | Balt | imor | e City |
| 3EC | 10a. STATE 10b. COUNTY | 0 | 10c. CITY, T | OWN OR LOCATIO | ON | | | | 10 | d. INSIDE CITY |
| | MARYLAND BALTI | IMOVE CITY | BA | LTIMO | VE ZIP CODE | _ | | 10a CITIZEN | 1) | YES 2 NO |
| FUNERAL | 412 George Str | reet | | 2 | 1201 | | | 115 | A | II COOMINIT |
| S | | 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 | | | NDENT OF HISPAN | | | or No- 14. | RACE | American Indian, /hite, atc. |
| ВУ | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TES | | | | 1 | Specify: | 21/ |
| | 15, DECEDENT'S EDUCA' | TION 16 | . DECEDENT'S US | UAL OCCUPATION | / | 16b. | KIND OF BUS | I /_ | JHC. | K |
| COMPLETED | (Specify only highest grade co | college (1-4 or 5+) | (Give kind of work life. Do NOT use re | done during most | of working | | , | | | |
| APL | 12 | | Domes | TIC | | 1 | 1/A | | | |
| Ö | 17. EATHER'S NAME (First, Middle, Last) | 1 | | | 18. MOTHER'S NA | ME (First, M | liddle, Maiden | Sumeme) | 3 | |
| BE (| Charles Davi | s Lee | | | Minni | e (| reel | 1 | | |
| 10 | 19e. INFORMANT'S NAME (Type/Print) | 7 | 196. MAILING AD | 1 0 | d Number or Rural I | Route Numb | er, City or Town | n, Stete, Zip Co | de) < | 212,07 |
| | Hrnold Keynolas | 2 | 10.1114 | lus G | t. 15A | uln | 101-E | MAR | ЦA | nd |
| | 20e_METHOD OF DISPOSITION 125 Buriel 2 Cremation 3 Remove | al from State 20b.PL/ | ACE AND DATE OF D y, cremetory or other | place) | 201 | DATE | 10- | CATION — City | or Town | N. MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | y INEINO | | ADDRESS OF FA | 30 196 | DAI | iciaus | 1000 | NITTO |
| | 6/1:11 | 91/ | 10- | UNIT | 1 FUR | eva | 1 Ho. | me | | |
| | Aulle | House | X | 108 CC | 2. Norti | 1 Ac | enve | | TO. | MD 21201 |
| | 23. PART I. Enter the diseases, or con shock, or heart failure. Lie | inplications that caused the at only one cause on each | ime. | enter the mod | e of dying, suc | h sa cerd | lsc or respi | ratory srreat | | Approximate interval Between |
| | IMMEDIATE CAUSE (Fine) | 37 3. 1 3 27 | 1 | | | | | | | Onset and Death |
| | resulting in death) a. | Multiple Mg | | | | | | | | |
| _ | | Diabetes Mel | | | | | | | | |
| Ŏ. | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CO | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury | Hypertension | 1 | | | | | | | |
| F | that initiated events | DUE TO (OR AS A CO | NSEQUENCE OF): | | | | | | | |
| ER | resulting in deeth) LAST | | | | | | | | | |
| AL C | PART ii. Other aignificent conditions | contributing to death but r | not resulting in t | the underlying | cause given in | Part i. | 24s. WAS AN | | | ERE AUTOPSY FINDINGS |
| SA | | | | | | | PERFOR | | CC | MILABLE PRIOR TO OMPLETION OF CAUSE |
| AED | | | | | | | | X | l . | F DEATH? |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF [| DEATH YES | □ NO □ | UNCERTAIL | N 🗆 | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | PLACE DF DEATH (| (Check only one) | | | | | | |
| YSI | 1 □ YES 🌠 NO | HOSPITAL: Inpatient 2 ER/Outpatient | nt 3 🗆 DOA 4 | | 5 - Reeldence | 6 🗆 Other | (Specify) | | | |
| H | 27. MANNER OF DEATH 15. Value 5 Pending | 26e. DATE OF INJURY (Month, Day, Year) | 26b. TIME O | Y WOR | HC? | 26d. DEŞ | CRIBE HOW I | NJURY OCCUR | ED | |
| BY | 2 Accident Investigation | On DIAGE OF MUNICIPAL | At b | M 1 71 | ES 2 NO | | | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify) | At nome, term, atte | et, tactory, office | | | or Town, Stete) | end Number or | Hurer Hou | te Number, |
| COMPLET | 29e. CERTIFIER XX | | | | | | | | | |
| MP | | AN: To the best of my knowledg On the beele of exemination en | | | | | | | euse(s) e | od manner as stated |
| 000 | | | and investigation, | | | | ena piece, en | | | |
| B | 29b. SIGNATURE AND TITLE OF CENTAGER | -did MAD |) | | 39256 | WOEK | | | | y 25,1996 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type. Pri | int) | | | | | | , -,-,-,- |
| | M.R. Zindelhadid, | | | | HOspital | Ĺ | | | | |
| | ri.N. ZHIGEHIAGEG, | 11.0. 0/0 1141 | 7 | | | | | | | |
| 1, | 31. DATE FILED (Month, Day, Year) FEB 1 4 1996 | d2. REALSTRAP'S SIGNAL | | | 1 | | | | | |

7.5

3. TIME OF DEATH

2. DATE OF DEATH DAY YEAR February 11,1996

BALTIMORE, MARYLAND 21215-0020 ter death. Page 6 may be retained by the hospital or attending physician.

FOR STATE REGISTRAR

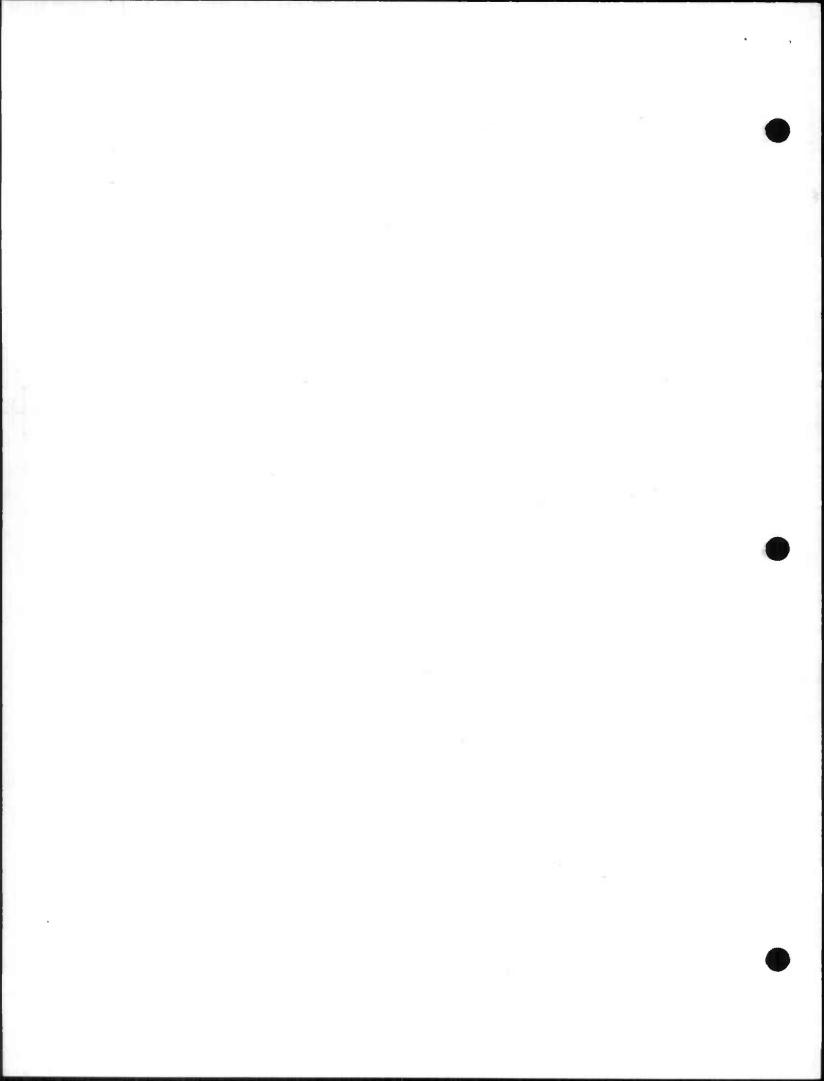
1. DECEDENT'S NAME (First, Middle, Lest)
Mary Elizabeth Ruggiero

DIVISION OF VITAL RECORDS, P.O. BOX 6876.

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| death | , |
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| HOSPING OF MITTINGING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page | |
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| | | 216-05-3626 | | 1 🗆 M 2 🗶 F | 83 | YRS. | ONTHS DA | | June 03,1 | 912 Ma | fryland | |
|--|-------------------------------|--|--------------------------------|--|---|---|---------------|--|---|-----------------------|---|--|
| 2, 3 should | CTOR | 90. FACILITY NAME (# not he Good Samari | tan Ho | | | 9 | | altimore (| | 9c. COUNTY | N/A | |
| Pages 1, | DIRECTOR | too. STATE Maryland | 10b. COUNT | | | | timor | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| usit permit. | FUNERAL | too. STREET AND NUMBER | | | | Dair | CIMOI | 101. ZIP CODE 212 | 21/1 | | I OF WHAT COUNTRY? | |
| as the burlal-transit permit. Pages | BY FUN | 11. MARITAL STATUS 1 Never Merried 2 X 3 Widowed 4 Dive | Married | 12. WAS DECEDED FORCES? (IF YES, GIVE) | YES 2 | NO | If yes | | NIC ORIGIN? (Specify Y an, Puerto Rican, etc.) | ee or No.— 14. | RACE — American Indien, Black, White, etc. Specify: White | |
| nse | ETED | (Specify on | EDENT'S EDU y highest grade | completed) | | Give kind of wor | BUAL OCCUP | PATION 7 most of working | 16b. KIND OF B | USINESS/INDUS | TRY | |
| thed for | MPLE | Elementary/Secondary (t | 3-12) | College (1-4 or 5 | +) | Cle | | | U | .S. Gov | rt. | |
| be detached for | BE COMPL | 17. FATHER'S NAME (First, N. William E. | | | | | | | AME (First, Middle, Meide Myers | n Sumame) | | |
| 5 should notified | O B | 19e. INFORMANT'S NAME (| | | | | | | Route Number, City or To | wn, State, Zip Co | de) | |
| 900 | | Harry F. R | | | 20b. PL/ | CE AND DATE OF | | as 10e | DATE 20c, L | OCATION City | or Town. State | |
| must | | 20e. METHOD OF DISPOSIT 1X Buriel 2 Cremetic 4 Donation 5 Other | | oval from State | | | | metery | 2/15/9 B al | timore | City, Marylan | |
| e funeral | | L'éonard Baltimore, Maryla | | | | | | | | | | |
| ss been signed by the attending physician and completely filled in by lept. of Health and Mental Hyglene prior to burial, cremation, or remited shows any Injury, or other traumatic event, the medical shows any injury, or other traumatic event, the medical shows any injury, or other traumatic event, the medical shows any injury, or other traumatic event, the medical shows any injury, or other traumatic event, the medical shows any injury, or other traumatic events. | SICIAN: MEDICAL CERTIFICATION | IMMEDIATE CAUSE (Flidiseese or condition resulting in death) Sequentielly list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injuthat Initiated events resulting in death) LAS PART II. Other algnification. | elons, dilete ING | a. DUE TO b. OUE TO c. DUE TO d | O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) | INSECUENCE OF): NSECUENCE OF): NSECUENCE OF): | con | lial understanding liable with the second lia | Pert I. 24a. WAS / PERF | IN AUTOPSY DRMED? | interval Batwee | |
| tere item | SICI | EXAMINER? | | HOSPITAL: | | | THER: | Home 5 - Reeldence | 6 Other (Specify) | | | |
| DHECTURY After this certification with the Street is marked, or | ву РНУ | 27. MANNER OF OEATH 1 Natural 5 2 Accident | Pending Investigation | | Day, Year) | 28b. TIME (| M 1 | INJURY AT WORK? | 28d. OEŞCRIBE HOW | INJURY OCCUP | RED | |
| m 28 is | | 3 Suicide 8 Homicide | Could not be determined | 28e. PLACE (building | otc. (Specify) | At home, farm, stre | eet, fectory, | office | 281. LOCATION (Stree City or Town, Stat | t end Number or e) | Rural Route Number, | |
| E 13 E | COMPLET | 000) | | | | | | | e to the cause(e) end me time, data end place, | | euse(e) end manner es stated. | |
| TO THE FUNE be filed within IMPORTANT: | TO BE C | 29b. SIGNATURE AND TITLE | al | v'C' | · RI | 7'0 | | 29c. LICENSE NU POS | IMBER | | ruary 12,1996 | |
| | - | 30. NAME AND ADDRESS OF | VI | PATE | AR'S SIGNATU | 89 | 03 | HAR | FOPD | P148 | 2/2-34 | |
| | | FEB 1 4 199 | | | n-Rande | | | | | | DHAM 18 Pau | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



WRC 96-0674-510

Item4c,20b 2-14-96 FilmG732 W.H.Per F/H Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, PER State of Maryland / Department of Health and Mental Hygiene O C

| | MI | 0 | FILM G-733 3/4/96 t.t | Otato of Me | in y lear loa 7 | | te of Death | na monatri | Reg. No. | o U | 3941 |
|----------------|---|---------------------|--|--|--------------------------|--|---|--|-----------------------------------|---------------------------------------|---|
| | Physici | an | 1. Decedent's Name (First, Middle, Last |) | | | | 2. Dete of De Month | eeth Dev | Yaar | 3. Time of Death |
| 4 | /Medi | | RAPHAEL | | ROB | INSON | | FEB. | 11, 19 | 96 | 2:27 PM |
| j | Examir | er | 4a. Facility Name (If not institution, give | | | | 4b. City, Tow | n, or Location of Daar | Balti | y of Death | 0.1. |
| - | From 1 | | JOHNS HOPKINS 5. Social Security Number 6. Se | | L e (In yrs. lest bii | thday) If Unda | BALTT r 1 Yaar If Under 2 | MORE | GBald | | |
| | Funeral Director | | | 2M 2□ F | | Yrs. Months | | 4 Hrs. 8. Data of Bi Min. (Month, D Sept | ey, Year) 4 95 | | iaca (Stete or Foraign try) yland |
| | Aarylend I show | jo | 10a. State 10b. County | | 10c. City, Tow | | | | | 10 | 0d. Inside City Limits 1 Yas 2 No |
| | 28a- | rect | Maryland N/A | | Balti | | o Code | | 10g. Citizen of | What Coun | |
| | 23e or | rai Di | 222 South Spri | ng Court | | | 21231 | | JSA | | .,, |
| 21215-0020 | permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Medical Expriner must be notified at ance. | by Funeral Director | 11. Maritai Status 1 □ Nevar Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Wes Decedent E Armed Forcas? 1 ☐ Yes 2 ☐ N If Yes, Give Yeer or Detes: | Evar in U,S. | | dent of Hispanic Origi cify Cuban, Maxican, 2 No Specify: | in? (Specify Yes or N Puarto Rican, atc.) | 2015 | ce - Amarica lok, Whita, a Yack | |
| 5-0 | 72 h | eted | 15. Decedant's Edu (Specify only highest grad | cation e completed) | 16a. | Decedent's Usu | el Occupation ork done during most (ise retired) | of working | 16b. Kind of B | usiness/Ind | Justry |
| 121 | within ne. hen | Completed | Elementery/Secondary (0-12) | College (1-4or 5 | +) | | se retired) | | DT / A | | |
| d 2 | be filed v tal Hygie d other t event, th | | N / A 17. Fether's Nama (First, Middle, Last) | | IN | / A | 18 Mother | 's Neme (First, Middle | N/A | mal | |
| Maryland | d be ental | To Be | Yul Raphael Ro | binson | | | | ea Whitel | | ,,,,, | |
| ary | should nd Men marke umatic | F | 19e. Informent's Name/Reletionship (Ty | | 196 | . Melling Addres | s (Street and Number | | | , Stata, Zip | Code) |
| | and 2 saith a n 27 is | | Trea Whitehead/ | Mother | | | th Spring | | | | 21231 |
| ore | of He | | 20e. Method of Disposition | in a sint harm Out in | 20b. Plece o | f Disposition " | Zion | Dete | 20c. Location | | |
| Ē | Peges nent of P ant: If its ury or of | | 1 ☐ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Othar (Specify) | emovel from State | Mou. | | | 2/17/96 | Lansdo | own M | laryland |
| Baltimore, | permit. Departr Importa any Inje | 1 | 21. Signature of Funerei Service Licens | 1 DI | Mo | Unity | Addrass of Facility Funeral | l Home | 72 | 14.1 | 01.001 |
| | | | 23a. Part1. Enter the disaase, or complishock, or heert leilure. List only or | cations that caused ne cause on each lin | the death. Do | not antar tha mo | V. North da ol dying, such es c | ardlec or respiratory | BAILO. | Md. | Approximate interval Between Onset and Death |
| þ | Physician / /Medicai | | Immediate Cause (Final disease or condition | SUDDE | INFANT | DEATH SYNI | DROME | | | | Onset sing Osatii |
| | Examiner | e | resulting in deeth) |) | Due to (or es e | consequance ol) | niw ly | | | 1 | |
| | ificate be axecuted g physician and as the burial-transit | Examiner | Sequentially list conditions, |). ———————————————————————————————————— | Due to (or as e | consequance ol) | | | | 1 | |
| 60, | be ax ician burial | a E | Sequantially list conditions, if sny, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events | · | | | | A | | | |
| k 68760, | 5 0 4 | Medical | resulting in daeth) Last | | Dua lo (or as a d | consequence ol): | | | | | |
| P.O. Box | that the deeth cer ed by the attendir detached for use | Physician/M | | | | | | | | i | |
| o. | the de | iysic | Part II. Other significant conditions con | tributing to death bu | t not resulting in | the underlying | causa given in Pert I. | 23b. Did | | | the cause of death? |
| o, | gned by | by Ph | | | | | | | Yes 2 No | 3 Prob | bebly 4 Unknown |
| Vital Records, | The iew requires that the deeth cer ste hes been signed by the attendin page 2 should be detached for use | Completed | | | | | | | s an autopsy ormed? | ave cor | ere autopsy findings ellable prior Io mpietion of cause death? |
| Œ. | ysician: The is s certificate he director, page | E O | | | | | | i)× | Yes 2□No | 10 | ∃Yas 2□ No |
| ita I | ician: The certificate rector, pag | Be | 25. Wes case referred to medical exeminer? | | | | | of Deeth (Check only | one) | | |
| Division of | £ 5 5 | 2 | 1 Nennar of Death 1/21 Neturel 5 Pending | lospitei: 1 Inpatler 28a. Dete of Injun (Month, Dey | y 28b.1 | Time of njury | 28c. Injury et Work? | | how injury occu | | 0 |
| Sic | Attending f death. ector: After by the fune | ficat | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. Plece of Inju | rv - At homa, fa | m street lector | 1 Yes 2 N | | (Street and Num | ber or Rura | I Route Number |
| P | O THE PERSON | Certification: | « 🗆 nomicida | building, etc. | (Specify) | , 61.661, 10010 | y, 511155 | City or To | wn, Stete) | | |
| | To the How within 24 has To the Fund completely the | edicai | 29a. Certifiar (Check only one) Certifying Physical Continue Certifying Physical Continu | ician: To the best of er: On the bests of and mennas stat | examination an | , deeth occurred d/or investigation | at tha time, date end , in my opinion, daath | plece, end dua to the occurred at tha time, | cause(s) and m data and place, | anner as st and due to | ated. the ceusa(s) |
| | To the within 2 To the comple | M | 29b. Signature and titla of certifier | 2 01/10 | () | 29 | c. Licansa number | | 29d. Data signa | ad (Month, I | Day, Year) |
| | 4 | | fully | Hall | \mathcal{A} | 1 | O.C.M.E | • | FEB. | 12,] | 1996 |
| | A | | 30. Neme and eddress of person who | mpleted oguse of de | ath (Item 236) | (Typa, Print) | | | | | |
| | | | MAGO FGOLY | JIP M | 2 111 | Penn | Street, | Baltimor | e, Mar | yland | 1 21201 |
| | Sta Registr | | 31. Dete FEB 1 4, 1996 | July allow | sor harda | lb. | | | | | |

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene D Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Tima of Deeth Month 96 750 d 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth UNIVERSITY HOSPITAL BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthpleca (Stata or Foraign Country) 1□M 2 F Months Days 215-01-6959 83 Feb.12,1912 Virginia Usual Rasidance of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore 1 ☐ Yas 2 ☐ No 112 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? 827 N. Arlington Ave., Apt. 21217 USA 12. Was Decedent Ever in U,S. 13. Wes Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Rece - American Indian Armed Forces?

1 Yas 2 No
If Yas, Giva Black, White, atc. 1 ☐ Navar Married 2 ☐ Married 1 Yes 21 No Specify: 3 XWidowed 4 ☐ Divorced Yaar or Datas: Black 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Eiamantery/Secondary (0-12) Coilaga (1-4or 5+) In Home Seamstress 12th 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surnama) John Hodge Adelaide White Hodge 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Vernell Clark-daughter 5200 Fernpark Ave., Baltimore, MD. 21207 20b. Piece of Disposition (Nama of cematary, cramatory or other piece) 20a, Mathod of Disposition Data 20c. Location - City or Town, Stata 1X Buriel 2 ☐ Cramation 3 ☐ Ramovai from Stata Mt. Calvary Cemetery 2/15 Baltimore, MD 5 Othar (Spacify) 21. Signature of Funeral Sarvice Licensae 22. Nama and Addrass of Facility LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVENUE 21207 the disaasa, or complications that caused they eeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, in disaasa, or complications that caused they eeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, in disaasa, or complications that caused they eeth. Approximata Intarvai Between Onset end Death showal vascular disease Immediete Causa (Final disease or condition rasulting in daath) Due to (or as a consequence of) Due to (or es e consaquence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings available prior to 24e. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Examiner

Physician/Medicai

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Certification:

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Physician

/Medical

Examiner

Director

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10a. Stete

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Director

r then "natural", or items 23s or 28s-f shore. The Medical Examiner must be notified at

the

with

filed within 72 hours efter death

Hygiene.

i. Peges 1 end 2 should be filed w tment of Heelth and Mental Hygien tant: If Item 27 Is marked other ti ijury or other traumatic avent, In

permit. Peges Depertment of Important: If Its any Injury or o

21215-0020

Baltimore, Maryland

buriel-transit the 8 ettending USB 5 deteched signed by page 2 should be peeu certificate hes director, After this funeral death. efter death in by the

that the deeth certificate be executed

aw

The

Hospital or Attending

To the

within 24 hours e To the Funeral C

Vital Physicien:

of

P.O. Box 68760,

Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaasa or Injury that initiated evants resulting in daeth) Last

25. Was casa rafarred to madical axaminar?

1 Yas 2 No

27. Manger of Death

Netural

2 Accident

3 Suicida

4 ☐ HomicIde

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| ca of Death (C | heck only ona) | |
|----------------|----------------|----------|
| Nursing Home | 5 ☐ Residence | 6 □Other |

Othar: 4 (Specify) 28d. Dascribe how Injury occurred

1 Inpatiant 2 ER/Outpetient 3 DOA
Data of Injury
(Month, Day Year) 28b. Time of Injury
28c. 28c. Injury et Work? 1 ☐ Yas 2 ☐ No

Piace of Injury - At homa, farm, straat, factory, office building, etc. (Spacify)

28f. Location (Straet and Number or Rural Route Number, City or Town, Stata)

29a. Certifier

5 Pending invastigation

8 Could not be datarmined

Cartifying Phyaicien: To the bast of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner stated.

29b. Signatura and title of certifier

29d. Date sigped (Month, Day, Year)

30. Nama and addrass of person who complated cause of daath (Itam 23a) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year)

FEB 1 4 1996

32. Ragistrar's Signatura

hi deveros he

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

03943

| | | | | Cen | incate of Death | | Reg. No. | | |
|------------|--|-------------------|---|----------------------------|---|-----------------------|-------------------------------------|-----------------------------|------------------------------|
| r | Physic | ian | 1. Decedent's Nama (First, Middla, Last) | | Stevens | 2. Data of C Month | Dev | Year | 3. Time of Deeth |
| | /Medi | cal | 4a. Facility Name (If not institution, giva street and number) | | 4b. City, Town, or | 1-eb | 10.1 | 996 | 1.25 P.1 |
| 4 | Exami | ner | 5332 Manle Avenue | | By L | Location of Dec | - ' | VA | |
| | Funeral | 0 | 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last | t birthday) | If Under 1 Yeer If Under 24 Hrs | | irth | 9. Birthplec | e (State or Foreign |
| | Director | | 212-44-4485 1×M 20 F 50 | Yrs. | Months Days Hours Min. | Sept 1 | 4,1945 | Country) | N.C. |
| | and * | | Usuel Rasidance of Dacedant 10e. State 10b. County 10c. City. T | Town or Loca | ation | | | 104 | Inside City Limits |
| | f aho | 0 | 11.1 | Himo | | | | 100. | 1 □ Yas 2 □ No |
| | 28a | rect | 10e. Street and Numbar | V 1 E 7 7 1 0 | 10f. Zip Code | | 10g. Citizen of V | /het Country | 7 |
| | 3a or | DIE | 5332 Maple Avenue | | 21215 | | 11. | SA | |
| | death | Funeral Director | 11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? | 13. W | as Decedant of Hispenic Origin? (S Yas, specify Cuban, Maxican, Puer | pecify Yes or N | io- 14. Reci | - Amarican k, Whita, atc | |
| 20 | 72 hours after death with the Manyland netural", or itema 23s or 28s-f show deal Examiner must be notified at | y Fu | 1 Navar Married 2 Married 1 Yas 2 No | | ☐ Yas 2 ☐YNo Specify: | 01110411, 010.7 | Specify | 0 1 | . 10 |
| 9 | "netural", or | d by | 3 ☐ Widowed 4 ☐ Divorced Yaer or Datas: | | | | | Dia | CIC |
| 21215-0020 | in 72 nan | Completed | (Specify only highast grada completed) | (Giva ki lifa. D(| nt's Usual Occupati <i>on</i> ind of work dona during most of wo O NOT use retired) | rking | 16b. Kind of Bu | Isinass/Indus | itry |
| 212 | filed within Hygiene. ther then " | mo: | Elamentary/Secondary (0-12) Collega (1-4or 5+) | Car | penter | | Sol | Koh- | 7 |
| nd | al Hy | Be | 17. Fathar'a Nama (First, Middle, Last) | | 18. Mother's Nei | na (First, Middl | a, Maidan Sumam | a) | |
| yla | 12 should be finance and Mental Harmarked of | 2 | James Hubbard | | tuely | 2 5 | tevens | | |
| Maryland | s 1 and 2 should be filed within 72 hours after death with the Manylar if Health and Mental Hyglene. Item 27 is marked other than "natural", or itema 23s or 28s-f ahow other traumatic event, fire Medical Examiner must be notified at | | | 19b. Mailing | Address (Street and Number or A | | ber, City or Town, | Stata, Zip Co | ode) |
| | 1 and Health em 27 other tr | | 20a. Mathod of Disposition 20b. Plac | e of Disposi | tion (Nama of | Data | 20c. Location - | City or Town | CIVIS Stata |
| OLL | Pages nent of h nt: If ite iry or of | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) | etery, crama | atory or other place) | 2/16/96 | Randa | 11.1. | |
| | 그는돈은 | | 21. Signature of Funaral Sarvice Licansaa | 22, | Name end Address of Fecility | | 1 lareca | 100 | 011, 19 |
| ä | Deparition of the party is | | Capsialla Corell |) M | arch F. H. Well | h Dien | 10 Bn1 | Lind. | 717-15 |
| | | | 23a. Part1. Entar the diseese, or complications that caused the deeth. I shock, or haart failure. List only ona causa on each lina. | Do not antar | tha moda of dylng, such es cardia | or respiratory | errest, | Ar | oproximata tarval Between |
| V | Physician | | Street, or the street and street | | | | | | nset and Death |
| | /Medical Examiner | 7 | Immadiata Ceuse (Final disaase or condition rasulting In death) Metastatic | : Lu | ing Cancer | | | Ť | yr. |
| | | je e | Due to (or ea | s e conseque | ence of): | | | | |
| | d d ansit | Examiner | Sequentially list conditions. Due to (or se | | | | | 6 | months |
| oʻ | certificate be executed nding physician end use es the bunel-transit | | | | tructure Pulv | unuar | 4 Aprens | | |
| 68760, | hysici the br | dica | Cause (Disease or injury that initiated avents rasulting in death) Lest Dua to (or as | | | | 1 000 | | |
| ox 6 | n certific anding p use es | Physician/Medical | d | | | | | | |
| | | clan | | | | | | Ì | |
| o. | The faw requires that the death ate has been signed by the ette page 2 should be detached for | hysi | Part II. Other significant conditions contributing to death but not resulting | ng In tha und | farlying cause given in Part I. | | | | e cause of death? |
| Œ. | signed b | by Pl | | | | 10 | Yes 2 No | 3 Probab | ay 4 □ Unknowi |
| Records, | require been sig should b | Pe | | | | | s an autopsy formed? | 24b. Wara | autopsy findings |
| 900 | e law requ has been je 2 shoul | ple | | | | po. | | | lation of causa |
| | | Completed | | | | 10 | Yas 2 No | 1□Y | as 2 No |
| Vital | ician: The certificate rector, pag | Be | 25. Was casa rafarred to medical axaminer? | | 26. Place of De | ath (Check onl) | one) | | |
| of | this al di | . To | | VOutpatient 3b. Tima of | | | sidance 6 Othe how injury occurr | | |
| 0 | aling After fune | tlon | 1 Natural 5 Panding 2 Accidant Invastigation (Month, Day Year) | tnjury | 28c. Injury at Work? M 1 Yas 2 No | 200. Describe | now injury occur | eu | |
| Division | l or Attanding efter death. Director: After I in by the fune | ifica | 3 Sulcida 6 Could not be determined 28a. Place of Injury - At home | e, farm, strae | at, factory, office | 28f. Location | (Streat and Numb | er or Rural R | outa Number, |
| ā , | s effe s effe ed in | Certification: | 4 Homicide building, afc. (Specify) | | | City or 1 | own, State) | | |
| | To the Hospffel or Attanowithin 24 hours effer deatl To the Funeral Director: completely filled in by the | edical | 29a. Cartifiar (Check only 20 Medical Examinar: On the best of my knowle 20 Medical Examinar: On the basis of examination | dga, death c | occurred at the time, date and place | , and dua to th | a cause(s) and ma | nnar as state | ed. |
| | vithin 2. within 2. To the F complete | Medi | and mannar stated. | Tarico or live | | mod at the time | | | |
| | 5 1 × 5 9 | | 29b. Signeture end titla of certifier | 1 | 29c. License number | | 29d. Data signed | 3 196 | y, Year) |
| | 2 | | 30 Name and address of | ading | D38993 | | 411 | 2176 | |
| | -) | | 30. Name and address of person who completed cause of death (Itam 23 | ertu | Hahts Bat | timore | MP | 2121 | 15 |
| 1 | Sta | ite | 31. Data filed (Month, Dey, Year) | - J | | | | 2 1 00 1 | |
| | Registr | ar | TEB 1 4 1996 guna various parties | 3 ; | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 6 3944 item#16a&16b 2/14/96 film q732 ag per FH Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 1996 ANNA 0. STANLEY Feb. 4:30 PM 11, /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3915 Calloway Avenue, Apt. 313 Baltimore N/A | If Under 24 Hrs. | 8. Defe of Birth (Month, Dey, Year) | OCt. 27, 1914 If Under 1 Yeer 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months 1 M 2 M Devs 81 218-22-9994 Director Maryland Usuel Residence of Decedent death with the Maryland 10e Stete 10b. County ahow 10c. City. Town or Location 10d. Inside City Limits i Hygiene. other than "natural", or items 23a or 28a-f ahow rent, the Medical Examiner must be notified at N/A Director MD Baltimore 1 □Wes 2 □ No 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 3915 Calloway Avenue, Apt. 313 21215 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Memled 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Black. Be Completed by 3 Widowed 4 □ Divorced Year or Dates 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PACKER MANUFACTURER 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be and 2 should be and 2 should be and 3 should be a shou Joseph Watts Is marked Geneva Hughes Watts 2 traumatic 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Important if item 27 is not in item 27 is not in item 27 is not in item 27 is not in item 27 is not in item 27 is not in item. Victoria Merritt-daughter 3503 Rosedale Road, Balto., MD 21215 20e. Method of Disposition 20b. Plece of Disposition (Neme of Dete 20c. Location - City or Town, Stete cemetery, cremetory or other piece 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Arbutus Memorial Park 2/16 Arbutus, Maryland 4 Donak 5 Other (Specify) uneral Service Lice LEROY O.DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVENUE BALTO.21206 plications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, Approximete Interval Between Onset and Deeth **Physician** /Medical mmediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e cons Examiner 11 The law requires that the death certificate be executed burial-transit Sequentielly ilst conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lesf Due to (or es e consequence of) physician s the buria Box 68760. Physician/Medical Due to (or es e consequence of) use as attending for P.O. | ed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? No No 3 Probably 4 Unknown signed t Records. ò 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy peen page 2 s has 1 Ves 1□Yes 2□ No certificate Division of Vital nepital or Attanding Physician: Theoris after death.

neral Director: After this certificate y filled in by the funeral director, ps. 25. Wes cese referred to hotical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 26b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending 1□Yes 2□No Investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours all To the Funeral D completely filled in edical 29e, Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier MID lewar 30. Name and address of person who completed cause of de eth (Item 23e) (Type, Print) M.D. 2300 GARRISON BLVD. W. 32. Registrar's Signeture

Stulia Ohumber Randall 31. Dete filed (Month, Dey, Year) State 4 1996 Registrar FEB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Filmg, 732, item #8,2/14/96,CYW Department of Health and Mental Hygiene 6 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dev **Physician** LLOYD G. SCHNEIDER 5:05 Pm FEBRUARY 11 1996 /Medical 4a. Facility Name (If not institution, giva street end number 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Hospital Center If Undar 1 Year | If Undar 24 Hrs. | Months | Days | Hours | Min. Birthpieca (Steta or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (in yrs. iest birthday) 8. Dete of Birth Months Days 1X M 2□ F 79 Yrs. 214-05-2752 Washington D.C Usuel Residence of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d Inside City Limits Director Randallstown 1 Yas 202 No Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21133 3607 Briarstone Road U.S.A. Funeral 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Raca - Amarican Indian, Bleck, Whita, atc. 1 Never Merried 2 Married White 1 ☐ Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Food & Pharmaceutical Eiementery/Secondery (0-12) College (1-4or 5+) Sales Companies 4 years 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumerna) Ethel Davis Louis Schneider 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rurei Route Number, City or Town, Stete, Zip Code) 3607 Briarstone Road Mrs. Charlotte Schneider Randallstown, MD 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stata Carroll Cremation Service 2/11/96 Hampstead, MD 4 □ Domation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD Enter the disease or complications that coused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, or heart failure. List only one couse on each line. 21133 Approximete intervel Betw Onset end Death Immediate Causa (Final PULMONARY EMBOLUS minutes diseesa or condition rasulting in deeth) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dfd tobacco uss contributs to the cause of death? 1 ☐ Yas 2 ☑ No 3 ☐ Probably 4 ☐ Unknown BRAIN TUMOR þ 24b. Wara eutopsy findings syslleble prior to completion of cause of death? Be Completed 24e. Wes en autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Wes cese refarred to medicel axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yss april 10 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. fnjury at Work? Certification: 27. Menner of Death 28e. Dete of fnjury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 5 Panding Investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

attending physician and for use as the burial-transit that the death certificate be executed Vital Records, P.O. Box 68760, signed by the a The law requires o

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examinet must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death w Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" and injury or other traumetic even.

Physician /Medical

Examiner

with the Maryland

To the within 2 To the

State Registrar

Medical

29e Certifier

29b. Signeture end titla of certifier MD MD 29c. License number

1145770

1 Cartifying Physicisn: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

30. Name and address of person who complated cause of deeth (Itam 23e) (Type, Print)

TEBRUARY 11,1996

DENNIS ROY IMPERIO, NONTHWEST HOSPITAL

5401 OLD COURT NOND RANDAUSTOWN, MD 2/133

31. Date filed (Month, Day, Year) 32. Ragistrer's Signeture FEB 1 4 1996 > Julia Davidson-Bandage

FOR STATE REGISTRAR

1 -

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 1 | 1. DECEDENT'S NAME (FIRST, MICE | A. | SCHMEN | 41 | | | | | 2. DATE OF C | - DAY | 19 | 42 1 | 1:42 A M |
|---------------|--|--|---|-----------------|------------------------|-----------------------------|----------------------|-----------|--------------------|------------------------------|---------------|----------------------|---|
| | 4. SOCIAL SECURITY NUMBER | | | (In yrs. last b | nirthday) IF U | NDER 1 YEAR | - | R 24 HRS. | 7. DATE OF B | HTHE | 8. | BIRTHPL. Country) | ACE (State or Foreign |
| | 186-16-1810 | | X M 2 🗆 F | 72 | YRS. | | N OR LOCAT | | March | | | Penns | sylvania |
| SR | 90. FACILITY NAME (If not institu St. Agnes Ho: | | end number) | | 96. | | Balti | | | | | N/A | H |
| 5 | RESIDENCE OF DECE | | | | | | | | | | | | |
| DIRECTOR | Maryland 10 | B. COUNTY HOWAL | cd | | 10c. CITY, TO | Colu | | | | | | 71 | d. INSIDE CITY LIMITS? YES \$\langle \text{X} NO |
| FUNERAL | 6713 Seneca | Drive | Э | | | | 101. ZIP COI | | 046 | | _ | U.S. | A. |
| FUN | 11. MARITAL STATUS | | WAS DECEDENT EVER FORCES? 1 YES | | | | | | NIC ORIGIN? (S | | or No- 14 | | American Indian, White, etc. |
| BY | 1 Never Married 2 XMe 3 Widowed 4 Divorce | | W W II | DATES | | | ES 2 XNO | | | | | Specify: | White |
| E | 15. DECEDI (Specify only hi | ENT'S EOUCATION | ON pleted) | (Oive | EDENT'S USU | ione during | TION most of work | ing | 16b. KIN | D OF BUSI | NESS/INDUS | TRY | |
| COMPLETED | Elementary/Secondary (0-12 | e) C | ollege (1-4 or 5+) 2 | | ject N | , | er | | Dep | artme | ent Of | Def | ense |
| COM | 17, FATHER'S NAME (First, Middle | | | , | | | 16. MO | | ME (First, Middle) | | (urneme) | | |
| BE | Harry Schmeh | | | 405 | MAK ING AGG | 0500 (0 | | | Route Number, 0 | | Outs 75 C | a da l | |
| 2 | Barbara N. S | | | 67 | 713 Se | neca | Drive | e Col | lumbia, | | | | 046 |
| - | 20e. METHOD OF DISPOSITION 1 XBurlal 2 Cremation 4 Donation 5 Other (St | 3 Removal | from State | b. PLACE AN | obate of older pohor s | SPOSITION (ace) Ceme1 | Feb. | 15, | 1996 | | COTT (| | , State , Maryland |
| | 21. SIGNATURE OF EMIERAL S | SERVICE LICENS | | * | | 22. NAME | AND ADDR | | ACILITY | | | _ | al Homes |
| | | uean | 1 ste | | | 5555 | Twi | n Kno | olls Ro | oad C | olumb | ia, | Maryland |
| | 23. PART I. Enter the dise shock, or heel | | only one ceuse on | | th. Do not e | nter tha | mode of d | ying, suc | ch aa cardiac | or reapir | atory srres | it, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) | n, | VENTRIC | LLAR | 2 FIE | RIL | LAT | ION | | | | | 5 minutes |
| _ | | | CHRONI | A CONSEQU | JENCE OF): TRIA | | | | ATION | | | | 5 VEARS |
| ITIO | Sequentially list condition if any, leading to immedia | nta | DUE TO (OR AS | 0 - 1 | | | | | | | | | 15 |
| | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | | CCKONH DUE TO (OR AS | A CONSEOL | ALTE | <->> | D158 | -A5 | F | | | | 15 years |
| CERTIFICATION | resulting in death) LAST | d | 1 SCHEMI | c G | ARPIC | MY | OPAT | (H) | ? | | | | 18 months |
| | PART II. Other algnificant | | | | _ | | ying cause | given in | Part I. 24 | PERFORI | | | ERE AUTOPSY FINDINGS WAILABLE PRIOR TO |
| EDICAL | CERE | BROVE | SCULAR | VIS | EASE | | | | 1 | YES 2 | ™ NO | | OMPLETION OF CAUSE F DEATH? |
| 2 | DID TOBACCO USE | F CONTRIB | LITE TO CAUSE | OF DEAT | H YES | J NO | ₩ IIN | CERTAI | NΠ | | | 1 | TYES 2 X NO |
| IAN | 25. WAS CASE REFERRED TO I | | OIL TO CAUSE | | OF DEATH (C | | | CENTA | | | _ | | |
| Sic | 1 YES 2 NO | | OSPITAL: Kinpatient 2 - ER/Ou | itpatient 3 | | HER: Nursing i | tome 5 🗆 i | Reeldence | 6 Other (Sp | pecify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Per | | 26e. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY | | INJURY AT WORK? | □ NO | 28d, DESCRI | BE HOW IN | JURY OCCU | RED | |
| ED BY | 3 Suicide 6 Co | vestigation ould not be termined | 26e. PLACE OF INJUI building, etc. (Sp | RY — At hom | e, ferm, stree | i, factory, o | ffice | | 261. LOCATIO | ON (Street e. own, Stete) | nd Number or | Rural Rou | ite Number, |
| LET | 29e. CERTIFIER (Check only | YING PHYSICIAL | N: To the bast of my kno | wiedge, dest | th occurred at | the time. | late end place | e, and du | e to the cause(| e) and man | ner ee stated | | |
| COMPLET | one) | | on the beals of examinat | | | | | | | | | | end manner as stated. |
| BE | 901 at han | SOUPER SOUPER | MD ATT | ENDI | NG PH | Ysicif | | CENSE NU | MBER | | PEB | RUAR | Horeth, Day, Year) |
| 5 | JONATHAN S | | MD 3440 | W11 | 27) (Type, Prin | "Aren | WE S | inte : | 301 BAI | ctima | ze, MA | P-ylor | d 21229 |
| | 31. FEB1 41998 | 5 Jali | 32. REGISTRAR'S SIG | | | | | | | | | | |



| TO ME HIGH MARYLAND STATE THE CORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 TO ME HIGH MARYLAND STATE HIGH MARYLAND STA | ID THE SECTION. After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be made within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. |
|--|---|---|
|--|---|---|

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N | MENTAL HYGIENE |
|--|----------------|
| CERTIFICATE OF DEATH | REG. NO. |
| | |

| 1 | FOR STATE REGISTRAR | STATE OF MARY | AND / DEPARTI | | | MENTAL HYGIENE REG. NO. | | |
|--|--|--|---|--------------------------------|----------------------|--|-----------------------------|--|
| | | EPHEN | | DEFF | RRI | 2. DATE OF DEATH DAY | 1996 | 3. TIME OF DEATH 439/AHM |
| | 4. SOCIAL SECURITY HUMBER 142–36–5678 | 1 🔀 M 2 🗆 F | 50 YRS. M | F UNDER 1 YEAR ONTHS DAYS | | July 5, 194 | 45 Cour | NJ |
| | 9a. FACILITY HAME (If not institution, give a 7443 Hickory Log RESIDENCE OF DECEDENT | | 9 | Colum | R LOCATION OF DE | ATH | HOWAL | |
| | MD 106. COUNT HOWA | | | town on Locat lumbia | ЮН | | | 10d. INSIDE CITY LIMITS? 1 YES 2 1 NO |
| | 7443 Hickory Log | Circle | | 101. | 21045 | | 10g. CITIZEH OF USA | WHAT COUNTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 X Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 X HO | II yee, spo | | IIC ORIGIN? (Specify Yee on, Puerto Rican, atc.) | Bla | CE — American Indien, ck, White, etc. White |
| | 15. DECEDENT'S EDI (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | ilfe. Do NOT use i | rk done during mo retired.) | st of working | Nationa | | ity Agency |
| | 12 17. FATHER'S HAME (First, Middle, Last) Anthony Scaldef | 5+ erri | Electric | al Engi | 18. MOTHER'S NA | ME (First, Middle, Maiden S Frugoli | | icy agency |
| | 190. INFORMANT'S NAME (Type/Print) Gloria Lambert | | | | nd Number or Rural I | Route Number, City or Town, Lumbia, MD | State, Zip Code) 21044 | |
| 1 | 20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Ren 4 Donetion 5 Other (Specify) | noval from State co | b. PLACE AND DATE OF metery, crematory or othe Columbia M | em. Par | k 14, | 1996 Cla | ation — City or rksville | e, MD |
| | 21. BIGHATUME OF FUNERAL SERVICE LI | 1 20/0 | | Leroy 5555 T | M & Russ win Knol | sell C Witz ls Rd. Colu | ke Fune umbia, l | ral Home MD 21045 |
| | 23. PART I. Ener the diseases, or ehock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Attens S. Due to (OR AS | each line. clevotic A CONSEQUENCE OF): | Cardi | | haa cardlac or reepira | | Approximate interval Between Onset and Death Cass Years |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | · Hyper | A CONSEQUENCE OF): | eroleui | LA S | | | Years |
| The state of the s | PART II. Other algnificent condition recovering al | cousic | but not reaulting in | the underlying | g cause given in | Part I. 24e. WAS AN A PERFORM | MED? | Ab. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | RIBUTE TO CAUSE | 28. PLACE OF OEATH | (Check only one) | UNCERTAI | N P | | |
| i ruio | 1 Ses 2 MO 27. MANNES OF DEATH 1 Natural 5 Pending 2 Accident Investigation | t Inpetient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year) | tpetient 3 DOA 4 | OF 28c. INJ | URY AT | 8 Other (Specify) 28d. DE\$CRIBE HOW IN | JURY OCCUREO | |
| 200 | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJU building, etc. (S) | RY — At home, farm, str | rest, fectory, offic | | 281. LOCATION (Street or City or Town State) | nd Number or Run | il Route Number, |
| CMIT | (Check only | SICIAN: To the best of my known IER: On the beele of examination | | | | | | e(e) end menner es stated. |
| O DE | AT THE AND TITLE OF CERTIFIE | 5-MS | Deput | ME_ Co | D3 1 | MBER 473 | 29d. DATE SIGN | ED (Month, Gay, War) 3 11 96 |
| | | TOTE MM | 4565 HE | | K CONE | WAY EL | u'con | 21042 |
| | FEB1 4 1996 | 32. HEGISTRANS SI | AL CONTRACTOR | | | | | |

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| - | Type of Trint in Diack indelible link. Assure All Copies Are Legib | C. | | | | |
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| | State of Maryland / Department of Health and Mental Hygiene) | 0 | 3 | 91 | 4 | |
| | Cortificate of Dooth | | | | | |

| | | | | | | Cer | tificate | of l | Death | | | Reg. No | D. | | |
|---------------|--|---------------------|--|---|--------------------------|--------------------|--|-------------------|--|-----------------------|---|----------------------|-----------|---------------------------|---|
| | Physic | | 1. Decedent's Nama (First, Middia, L | 1 | Shar | 25 | | | | | 2. Data of D Month | | | Yaar 96 | 3. Time of Death |
| | /Medi Exami | | 4a. Facility Nama (If not institution, go | iva street and numbar) | 5 | | | 4 | Bal | 1 | ocation of Dea | | . County | of Death | |
| | Funeral Director | | 5. Social Sacurity Number 214-18-1791 Usual Rasidance of Decedant | 1□M 2⊠E | a (In yrs. iast bi 78 | irthday) Yrs. | If Undar 1 Months | Yaar Days | If Undar Hours | 24 Hrs. Min. | 8. Data of Bi (Month, D Nov . 15 | ay, Year, | 917 | 9. Birthp Coun Mary | laca (Stata or Foraign try) 1and |
| | Maryland a-f show | tor | 10a. Stata 10b. County | roll | 10c. City, Tow | vn or Loc | | esv | ille | | | | | 1 | 0d. Insida City Limits 1 ☐ Yas 2 万 No |
| | th with the 23s or 28 | Funeral Director | 10e. Street and Number 5628 | LaSalle La | ne | | 10f. Zip C | oda | 21784 | , + | | | | What Coun | • |
| 020 | ges 1 and 2 should be filed within 72 hours efter deeth with the Maryland it of Health end Mentel Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumstic event, as Medical Examiner must be notified at | by | 11. Marital Status 1 □ Nevar Married 2 □ Married 3€€Widowed 4 □ Divorced | 12. Was Decedant E Armed Forcas? 1 Yas 2 N If Yas, Give Yaar or Datas; | | | Vas Dacedar Yas, specify | | Ispanic Ori in, Maxicar Specify: | gin? (Sp n, Puarto | ecify Yas or N Ricen, atc.) | 0- | Bla | ck, Whita, | |
| 21215-0020 | within 72 ho iene. than *natur the Medical | Completed | 15. Decedent's E (Specify only highast g Elamantary/Secondary (0-12) 9th | Education rada compiated) Collega (1-4or 5 | +) | (Giva I iite. D | ent's Usuel (kind of work 00 NOT usa 1rant | dona d ratired | du <i>ring</i> mos | t of work | ing | | | sinass/ind | |
| Maryland 2 | should be filed withing and Mentel Hygiene. marked other than umatic event, the H | To Be C | 17. Father's Nama (First, Middia, Las | n Paul Avere | | Scac | Tanc | riai | 18. Moths | | a (First, Middle ana Fer | a, Ma <i>id</i> ar | Suman | | ce |
| | 1 and 2 sho Health end i em 27 la ma | | 19a. Informent's Neme/Raiationship Helen Franco | (Type, Print) Daugh | ter 5 | 628 | LaSa1 | 1e | | | ai Routa Numi esville | | | | Code) |
| Baltimore, | permit. Peges 1 and 2. Department of Health el Important: If Item 27 la any injury or other trau | | 20a. Method of Disposition 1 Burial 2 □ Cramation 3 4 □ Donation 5 □ Othar (Spec | | | ry, cram | atory or oth | ar piac | | Feb | Data . 14,199 | | | city or To | wn, Stata Maryland |
| Ball | permit. Pe Departmen Important: any injury 9056. | | 21. Signatura of Funaral Sarvice Lice | 7 Kell | ner | Lo | | yer | s Fu | nera | l Direc | | | | 4794 |
| | Physician /Medical Examiner | - | 23a. Part (Entar tha disbasa, or on shock, or haart fallura. List only immediate Cause (Finel disaasa or condition rasulting in deeth) | nplications that ceused yona causa on each lin | | not anta | r tha moda | of dyln | g, such as | cerdiac | or raspiratory | arrest, | | | Approximata Interval Between Onset and Death |
| Box 68760, | eath certificate be axecuted ettending physician end for use as the burial-transit | an/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in death) Last | . Thr | Dua to (or as a | consequ | uance of): | | | | 7400 | ~124 | 5 .5 | | |
| P.0. | requires that the death een signed by the etter hould be detached for u | y Physician/ | Part II. Other significant conditiona Inf. Erutin | - (| t not resulting l | 0 | 0 | | | | 23b. Did | 1 | usa co | | the causs of death? |
| Records, | aw Is b | Completed by | (Broot, hr | Colon C | ance | Ry | CH | F, | pept | 12 | 24a. Wa | s an auto formed? | ppsy | COI | are autopsy findings allable prior to mpletion of ceuse death? |
| of Vital R | yalcian: The last certificeta ha | Ве Соп | 25. Was cesa rafarred to medicel axaminar? | CVA, | Cata | 10 | etr | | | of Deat | 1 🗆 h (Check only | Yas 2 | Ø40 | 1 [| Yas No |
| bixision of \ | or Aending Physical Control of the funeral di | Certification: To | 27. Mannar of Death Natural 2 Accidant 3 Suicida 4 Homicida | oe oo Disas Mais | Year) 28b. | Tima of Injury | M 280 | | 4 🗆 140 | | oma 5 ☐ Ras 28d. Dascribe 28f. Location City or To | how inju | nd Num! | red | r) i Routa Number, |
| | To the Hospitalin 24 hours Within 24 hours To the Funeral completely filled | edicai | 29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa | hyalcian: To tha best of miner: On tha basis of and manuer stat | axamination ar | e, deeth | occurred et astigetion, In | tha tim | na, data an pinlon, daa | d place, th occur | and dua to the red at tha tima | causa(s , data sn | and made, | anner as st and dua to | ated. tha ceusa(s) |
| | To the vithin To the comp | M | 29b. Signature and little of certifler | HAK. | inu | De |) D | icansa 4 | 174 | 18 | | 29d. Da | ata signé | d (Month, | Day, Year) |
| | 10 | | 30. Nema and address of person who | EIM, MI | ath (Itam 23a) | (Type, F | Print) W | ÉS | t B | les | derE | Avs | f. | Balt. | m |
| | Sta Regist | | FEB 1 4 1996 | 12. Registra | Signetura | | | | | | | | , | | |

m n PO x

| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed whem 24 hours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | | |
|--|---|------------|--|
| the hospita | e detached 1 | | t once. |
| retained by | 5 should be | | IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| may be | r, page | | st be |
| 30e 6 r | director | | er mu |
| leath. P | funeral | | xamin |
| urs after d | In by the | r removal. | edical e |
| 24 ho | / filled | tion, or | the m |
| 1 with | mpleteh | . crema | event, |
| execute | and co | o bunial | natic |
| ate pe | ysician | prior 1 | r traui |
| certific | ding ph | -lygiene | r othe |
| death | e aften | fental P | טיץ, ס |
| hat the | J by th | and N | my in |
| uires ti | signed | Health | IWS BI |
| aw req | s been | pt. of | 3 she |
| The la | ate has | tate De | lem 2 |
| ICIAN: | ertifica | the St | 0. |
| ING PHYS | After this c | eath with | marked, |
| TEND | DR: A | offer d | 28 is |
| OR AT | DIRECT | OULS | lem 2 |
| MITAL | RALI | 172 h | N. H. |
| HOS | FUNE | Within | AN A |
| THE | THE DI | be filed | MPO |

| for 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | | |
|--|--|---|--------------------|-------------------------|--|--------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| GORDON | T | STUL | LER | | Feb 8 | | 6:30 am M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | a, Bi | RTHPLACE (State or Foreign |
| 217-38-3019 9e. FACILITY NAME (If not institution, give | | 4 YRS. | DAYS | HOURS MIN. | Jan. 6 1 | | ryland |
| Saint Joseph Me RESIDENCE OF DECEDENT 100. STATE 10b. COUN Md Raiti | A SECTION AND A SECTION AND A SECTION AND A SECTION AND A SECTION AND A SECTION AND A SECTION AND A SECTION AS | | | vaon, Mary | | | timore |
| I 100. STATE 10b. COUNT | TY | 10c. CITY, 1 | OWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| | rore | Park | wille | | | | 1 YES 2 NO |
| ≤ | Lane | | 101 | 21234 | | US US | DF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, QIVE WAR OR C | 2 NO | Il yee, sp | | IC ORIGIN? (Specify Yea, Puerto Rican, atc.) | | ACE — American Indian, Black, White, etc. |
| 15. DECEDENT'S ED (Specify only highest grad | UCATION le completed) | 16e. DECEDENT'S US (Give kind of wor | k done during mo | ON st of working | 16b. KIND OF BU | SINESS/INDUSTR | |
| 15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Lest) | College (1-4 or 5+) | Internal | | ox | Auto I | ndustry | |
| 17. FATHER'S NAME (First, Middle, Last) | | 1 | | 18. MOTHER'S NAI | ME (First, Middle, Melden | Surneme) | |
| m Henry | Carroll | Stull | er | Vivian | Eliz | abeth | Gill |
| 190. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AI | DRESS (Street a | nd Number or Rural R | loute Number, City or Tow | m, State, Zip Code |) |
| Mary Ann Stuller | | 8804 | Laliewo | od Rd. Pa | arkville M | d. 2123 | 4 |
| 20e. METHOD OF DISPOSITION 1 | | b. PLACE AND DATE OF | | | | son, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE | CENTEE | | 22. NAME A | D ADDRESS OF FAC | CILITY | | |
| 1 Koll | | | | uck Towso | n FE Rd. Towso | m MA 2 | 1204 |
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. MYOCARD DUE TO (QR AS | DIAL INFARC' A CONSEQUENCE OF: | TION | de or dying, sucr | n as cardisc or reap | iratory sirest, | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | C. | A CONSEQUENCE OF): | | | | | |
| PART II. Other algorificent condition | | but not resulting in | the underlyin | g ceuee given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| DIABETES MELLI OSTEOMYELTIS | | | | | 1 YES : | 2 700 | OF DEATH? |
| OSTEOMYELTIS DID TOBACCO USE CON | | OF DEATH YES | □ NO □ | UNCERTAIN | 1 X | | 1 D YES 2 DO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH | | | | | |
| Ø 1 □ YES 2 □ Y | HOSPITAL: | | THER: Nursing Hon | e 5 🗆 Residence | 6 Other (Specify) | | |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 27. MANNER OF DEATH 1 | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| ry wo | URY AT ORK? YES 2 NQ | 28d. DESCRIBE HOW | INJURY OCCURE | D |
| 3 Suicide 6 Could not b | 28a PLACE OF INJUS | RY — At home, ferm, streecity) | el, lectory, offic | • | 281. LOCATION (Street City or Town, Stefe | and Number or Ru | ral Route Number, |
| | SICIAN: To the beet of my knownER: On the beele of exeminati | | | | | | use(e) end menner ee stated. |
| III 295 SIOMATURE AND TITLE OF CERTIFI | | | | 29c, LICENSE NUM | | | NED (Month, Day, Year) |
| O intime of a d | D. de le | on, m | · D. | | 508 | 1 7mg | 6.8,1996 |
| NATIVIDAD DE LE | | | | SON MAD | VI AND SI S | M | |
| 31. DATE FILED (Month, Day, Year) FFD 1 / 100C | 32. REGISTRAR'S SIG | NATURE | ID TOW | GOIN, INIME | TUNIVU ETEL | ~ | |

Physician

/Medical

Examiner

1. Decedent's Neme (First, Middle, Last)

Virginia

4e. Feclfity Neme (If not institution, give street and number)

MOZELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

TOLIVER

طفاه ما ا ا ا ا ا State of Maryland / D

| epartment of Health and | mental | Hygiene |
|-------------------------|--------|----------|
| Certificate of Death | | Reg. No. |

2. Dete of Deeth

FEBRUARY 13, 1996

11,

1996

4c. County of Deeth

Month

FEBRUARY

4b. City, Town, or Location of Deeth

| 0 | 0 | 0 | 100 | 0 |
|----|---|---------|-----|-----|
| 11 | 0 | 4 | - | 1.4 |
| | | and the | | 1.3 |

3. Time of Death

3:32AM

| Funeral | | III DRUID PAR. | K LAKE DR | IVE | #1211 | | E | BALTI | MORE | | n, | /a | |
|--|-------------------------------------|--|---|---|--|--|-----------------|--|---------------------------|--|---|------------|---|
| Director | | 5. Sociel Security Number 579–38–1597 Usuel Residence of Decedent | . Sex 1□ M 2 TF | e (In yrs. k | | If Under 1 Months | Yeer Deys | If Under 2 Hours | Min. | Dete of Bird (Month, Da ay 10 | th y, Year) , 1927 | Co | hplace (State or Foreign untry) irginia |
| 8 m | | 10e. Stete 10b. County | | 10c. City | , Town or Local | tion | | | | | | | 10d. Inside City Limits |
| f ahow | 0 | Maryland n | /a | | Ra 1 | timo | re | | | | | | 1 Ves 2 □ No |
| 28a | Director | 10e. Street end Number | <i>,</i> 4 | | | 10f. Zlp C | | | | | 10g. Citizen of | What Co | untry? |
| 3a o | | 717 Druid Park | Lake Drive | Ap | t 1211 | | 212 | 17 | | | | USA | |
| "netural", or itams 23a or 28a-f sho siscal Examiner must be notined at | / Funeral | 11. Meritel Stetus 1 Never Merried 2 Merried | 12. Wes Decedent Armed Forces? 1 | Ever in U,S | tf Y | es Decede 'es, specif | | ispenic Orig in, Mexican, Specify: | in? (Specif Puerto Ric | y Yes or No en, etc.) | - 14. Re- Bie Specifi | ce - Ame | ricen Indien, e, etc. |
| E E | d by | 3 X Widowed 4 □ Divorced | Yeer or Detes: | | | - 700 2. | | ороспу. | | | Specii | | Black |
| | Completed | 15. Decedent's (Specify only highest) | grade completed) | | 16e. Deceder (Give kir. life. DO | nt's Usuel nd of work NOT use | done d | ation du <i>ring m</i> ost i) | of working | | 16b. Kind of B | Business/ | Industry |
| ont, tre M | Com | Elementery/Secondery (0-12) 6th Grade | College (1-4or 5 | i+) | | mest | | | | | Pri | vate | Family |
| 9 5 | Be (| 17. Fether's Neme (First, Middle, La | st) | | | | | 18. Mother | 's Neme (F | irst, Middle, | Meiden Sumer | me) | |
| raumatic eve | Lo | unknown | | | | | | Lorr | aine | Curry | | | |
| traumatic | | 19e. Informent's Neme/Reietionship | (Type, Print) | | 19b. Meiling | Address (| Street | end Numbe | or Rural F | oute Numbe | er, City or Town | , Stete, 2 | Zip Code) |
| 2 2 | | Lark Cooper | (daugl | | 4415 C | | | erick | Road | Ba: | ltimore | , MD | 21229 |
| | | 20e. Method of Disposition 1 | □ Pemovel from State | 20b. Pl | ece of Dispositi metery, creme | ion (Neme tory or oth | e of er pled | ee) | | Dete | 20c. Location | - City or | Town, Stete |
| ury o | | 4 Donetion 5 Other (Spe | | Woo | dlawn C | Cemet | ery | | Fe | b 14 | Baltim | ore | County, MD |
| any Injury or once. | | 21. Signeture of Funerel Service Lice | arken_ | | 250 |)I GW | ynn | s of Fecility S FA1 Mary | ls Pa | er Fui rkway 2121 | neral H | omes | , Inc. |
| sician | | 23a. Pert1. Enter the diseese, or co shock, or heert failure. List on | mplications that caused ty one cause on each iir | I the deeth | | | | | | espiretory a | rrest, | | Approximate Interval Between Onset end Deeth |
| edical | | | | | | | | | | | | | |
| niner | | Immediate Cause (Fine) disease or condition resulting in deeth) | . Arteri | | | | rdi | .ovas | cula | r Dis | ease | | |
| iel-transit | ledical Examiner | diseese or condition | b | Due to (or | erotic as e conseque es e conseque es e conseque | ence of): | rdi | ovas. | cula | r Dis | sease | | |
| or use as the buriel-transit | | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that inklated events resulting in deeth) Lest | b | Due to (or Due to (or | as e conseque es e conseque es e conseque | ence of): ence of): | | | cula | | | | |
| or use as the buriel-transit | Physician/Medical | disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Intilated events | b | Due to (or Due to (or | as e conseque es e conseque es e conseque | ence of): ence of): | | | cula | 23b. Did | lobacco usa co | | |
| igned by the ettending physician and I be deteched for use as the buriel-transit | by Physician/Medical | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that inklated events resulting in deeth) Lest | b | Due to (or Due to (or | as e conseque es e conseque es e conseque | ence of): ence of): | | | cula | 23b. Did (| lobacco usa co | 3 Pi | to the cause of death? robably 4 Unknown Were autopsy findings aveileble prior to completion of cause |
| ate has been signed by the ettending physicis page 2 should be deteched for use as the bur | by Physician/Medical | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that inklated events resulting in deeth) Lest | b | Due to (or Due to (or | as e conseque es e conseque es e conseque | ence of): ence of): | | | | 23b. Did 1 1 24e. Wes perfo | tobacco use co Yes 2 □ No an autopsy | 3 Pi | robably 4 Unknown Were autopsy findings avelleble prior to |
| ate has been signed by the ettending physician and page 2 should be deteched for use as the burlel-transit | Completed by Physician/Medical | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that intilated events resulting in deeth) Lest Pert II. Other algnificant conditions | b | Due to (or Due to (or | as e conseque es e conseque es e conseque | ence of): ence of): | | en in Pert I. | | 23b. Did 1 1 24e. Wes perfo | tobacco use co Yes 2□ No an autopsy rmed? GCTION Yes XIXNo | 3 Pi | were autopsy findings aveileble prior to completion of cause of deeth? |
| director, page 2 should be deteched for use as the buriel-transit | by Physician/Medical | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that inkleted events resulting in deeth) Lest Pert II. Other algnificant conditions 25. Wes case referred to medical examiner? | b d d Hospitei: 1 Inpatie | Due to (or Due to (or Due to (or ut not resu | as e conseque es e conseque es e conseque | ence of): ence of): | use giv | en in Pert I. | of Deeth (C | 23b. Did to 1 = 24e. Wes perfo | tobacco use co Yes 2□ No an autopsy rmed? GCTION Yes XIXNo | 3 Pi | Were autopsy findings aveileble prior to completion of cause of deeth? |
| his certificate hes been signed by the ettending physician and all director, page 2 should be deteched for use as the buriel-transit | o Be Completed by Physician/Medical | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that intilated events resulting in deeth) Lest Pert II. Other algnificant conditions | b d | Due to (or Due to (or Due to (or ut not resu | as e conseque es e conseque es e conseque Iting in the unde | ence of): ence of): ence of): ertying cau | Use give | en in Pert I. 26. Plece er: 4□ Nur | of Deeth (Gising Home | 23b. Did to 1 = 24e. Wes performed in S.P.E. 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 | tobacco use co Yes 2□ No an autopsy rmed? CCTION Yes XIXNo | 3 Pi | Were autopsy findings aveileble prior to completion of cause of deeth? |

Carter

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner so stated.

XIX Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Nonald & Wright MO

O.C.M.E.

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Dey, Year)

State Registrar

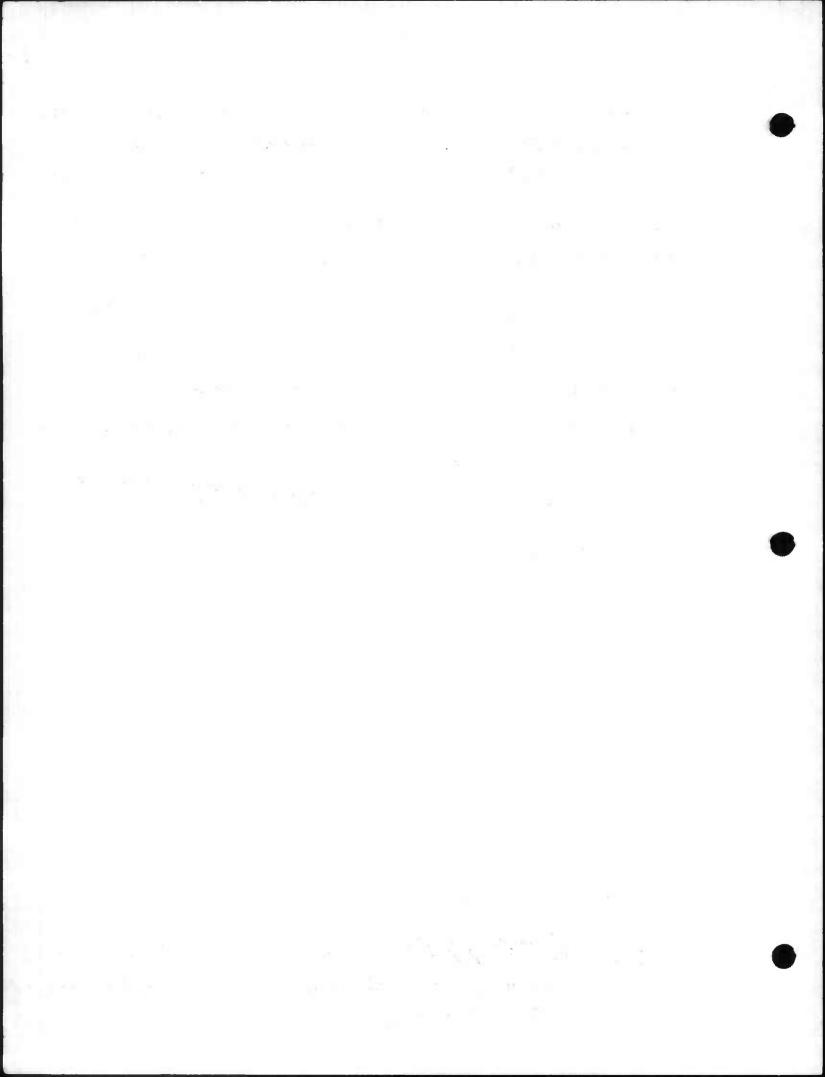
Medical

FEB1 41996



To the Hosp within 24 ho To the Fune completely fi

| | Item5 | 5 , Fi | State of Maryland / I Ilm732,2/14/96,1 PER.FH | Certificate of | | | ene 96 g. No. | 03951 | | |
|---|--|---|--|---|--|---|--|--|--|--|
| | hysicia /Medic Examin | al | Decedant's Name (First, Middle, Last) GLADYS THOMA 4a. Facility Nama (If not institution, give street and number) | S | | | Day Yaar JARY 09, 1996 5:1: | | | |
| Fu | ineral | | THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last bit | rthday) If Undar 1 Year Months Days | | Dete of Birth (Month, Day, | n/a Birth Day, Year) 9. Birthpleca (State or Fo Country) 7. 1928 Tennessee | | | |
| the Maryland 28a-f ahow notified at | | Director | Usual Rasidance of Decedant 10a. Steta 10b. County 10c. City, Tow Maryland n/a 10e. Street and Number | m or Location Baltimore 10f. Zip Coda | | 10 | g. Citizen of What | 10d. Inside City Limits 1 XYes 2 □ No | | |
| 72 hours after death with the Maryland | "natural", or frems 23s or 28s-f show edical Examiner must be notified at | by Funeral | 201 North Washington St. Apt. 41 11. Maritel Stetus 1 Navar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar In U.S. Armed Forces? 1 Yes 2 No If Yes, Giva Yaar or Dates: | .0 2 | 21231 Hispanic Origin? (Specify ean, Maxican, Puarto Rice Specify: | | USA 14. Race - Ar Black, WI | narican Indian, | | |
| within ene. | d other than "natur avant, tre Medical | Completed | 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12th Grade | 16a. Decedent's Usual Occupation (Giva kind of work dona during most of w lifa. DO NOT usa retired) Domestic | | | 6b. Kind of Businas | ss/Industry | | |
| Mer | marked other matic avant, | To Be C | 17. Fathar's Nama <i>(First, Middla, Last)</i> Earnest Howard | 18. Mother's Nama (Fit Lucille Bu | irst, Middla, Mi ncknan | aidan Sumama) | | | | |
| nd 2 | other tr | | Daniel J. Thomas, II 20a. Mathod of Disposition 1□ Burial 2\(\text{D}\) Cremetion 3□Removel from Stata 4□ Donetion 5□ Othar (Specify) 18 20b. Place of cemata Metro | 3307 Barney f Disposition (Nama of ny, cramatory or other pic) Crematory | Drive A | ccokee | per, City or Town, Stata, Zip Code) eek, Maryland 20 20c. Location - City or Town, Stata Catonsville, Mar | | | |
| Depar | any in | | 21. Signeture of Funaral Service Licensee Suy Lollus 23a. Pert1. Entar tha disaese, or complications that ceusad tha daath. Do shock, or haaf tailura. List only one cause on each line. | 2501 Gwyr Baltimore | ass of Facility Nutte ans Falls Pa e, Maryland ing, such as cerdiec or ra | rkway 21216 | | Approximeta | | |
| /Me | ician dical niner | | | | | | | 3 days | | |
| cate | Dar J | Sequantially list conditions, if any, leading to immadiate causa. Enter Underlying Ceuse (Disaase or Injury | | | | | | | | |
| that the | igned by the attendir | by Physician/Medic | Part 11. Other significant conditions contributing to death but not rasulting in | | | ite to the cause of death Probably 4.3 Unknown | | | | |
| a law requires | nas been s ge 2 should | Completed b | Insufficiency, (Andio | | | 24a. Was en performe | ed? | available prior to completion of causa of daath? | | |
| Physician: | mis certific | To Be | | Tima of 28c. Injury | 28. Place of Death (Cher: 4 Nursing Home ry at 28d. | 5 Residen | | pecify) | | |
| To the Hospital or Attending within 24 hours after death. | completely filled in by the funeral | Certification: | 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 3 ☐ Suicida 4 ☐ Homicida 3 ☐ Suicida 4 ☐ Homicida 3 ☐ Suicida 4 ☐ Homicida 4 ☐ Homicida 4 ☐ Homicida 5 ☐ Could not be datarmined 5 ☐ Could not be datarmined 5 ☐ Could not be datarmined 5 ☐ Could not be datarmined 5 ☐ Could not be datarmined 6 ☐ Could not be datarmined 7 ☐ Could not be datarmined 8 ☐ Could not be datarmined 9 | irm, straat, factory, office | | City or Town, | Stata) | Rural Routa Number, | | |
| To the Hospital | completely fi | Medical | 29a. Certifiar (Check only one) 29b. Signetura and title of certifier | 29c. Lican | sa number | t the tima, dat | d. Data signed (Mo | nth, Day, Year) | | |
| | 3 | | 30. Name and addrass of person who complated cause of death (Item 23a) | (Type, Print) 1 Nonth | 76000 | F | Phruan | y 91996 | | |



96-0574-510

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 6 0 3 9 5 2

| | 10##10 | oa 1 | 11# g/32 2/14/96 ag per FH | | Certificate | of | Death | | Reg. No. | 0 | 0 7 0 2 |
|-----------------------|--|----------------|--|-------------------|------------------------------|----------------|---|---------------------------------|-----------------------------------|---------------------|--|
| | Dhysio | ion | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | | Veer | 3. Time of Death |
| ţ | Physic /Medi | | WILLIE WILLIAM | | | VE | AL | FEBRUA | ARY 7, | 1996 | 10:58P. |
|) - | Exami | | 4a. Facility Name (If not institution, give street and number) | 9 | | 1 | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | |
| | | _ | 1620 MONTPELIER STREET | | | | BALTIMO | RE | N | /A | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age | (In yrs. lest bir | Months [| Year | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, De | Year) | 9. Birthpi Count | ace (Stete or Foreign |
| | Director | | @216-30-0846 6 | 0 | Yrs. | | | FEB 28 | | | NC |
| | and ** | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Tow | n or Location | | | | | 10 | Od. Inside City Limits |
| | Mary! | 0 | MD N/A | B/ | ALTIMORE | | | | | | X□ Yes 2□ No |
| | 28a | Director | 10e. Street and Number | | 10f. Zip C | | | | 10g. Citizen of | What Coun | trv? |
| | 72 hours after deeth with the Maryland natural, or items 23a or 28a-f show pical, Examiner must be notified at | | 1620 MONTEPELIER ST | | | | 218 | USA | | | |
| | me 2 | Funeral | 11. Marital Status 12. Was Decedent Ev | er in U,S. | 13. Was Deceden | nt of H | lispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- | 14. Rac | æ - America | |
| 5 | affer Ar ite | | Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No | | | | | Rican, etc.) | Bla | ck, White, e | |
| 2 | al', o | þ | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: | | 1□ Yes 2X | No | Specify: | | Specify | BL. | ACK |
| ה ה | natural', | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. | Decedent's Usual C | Occup | pation during most of work | loa | 16b. Kind of B | usiness/Ind | ustry |
| Mai yiaiiu 21213-0020 | E . | npie | Elementary/Secondary (0-12) College (1-4or 5+) | | life. DO NOT use | retire | d) CIRCULAR D | _ | | | |
| 4 | | Co | 10th | | DELIVER | M9 | CIRCUL | | MARK | | G CO |
| 2 | 0 = 0 5 | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mothar's Nam | e (First, Middle, | Meiden Sumen | ne) | |
| yie | | 2 | CHARLES VEAL SR | | | | WILLA | MAE ASI | KEW | | |
| | | | 19a. Informant's Name/Relationship (Type, Print) | | . Malling Address (S | | | | r, City or Town, | Stete, Zip | Code) |
| | CENL | | CHARLES VEAL JR 20a. Method of Disposition | | 41 HOFF Disposition (Name | | N ST BAI | TO, MD | 21213 | - | |
| 5 | 2 5 4 5 | | IND Burial 2 ☐ Cremation 3 ☐ Removal from State | cemeter | ry, cremetory or othe | er pla | ce) F] | EB Date | 20c. Location - | City or 10 | Mi, State |
| Daiminole, | t. Pa timer tant | | 4 □ Donation 5 □ Other (Specify) | MT ZI | ON CEM | | 14 | 1996 | BAL | TO,MI |) |
| 2 | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funeral Servica Licansee | _ | 22. Name and A | Addre | ss of Facility B] | ETTS FU | JNERAL | HOM | E |
| | 40144 | | Patricia Dello | | | | AROLINE | | | 212 | 13 |
| | | | 23a. Part1. Enter tha disease, or complications that caused the shock, or heart failure. List only one causa on each line. | ie death. Do i | not enter the mode of | of dyir | ng, such as cardiac | or respiratory ar | resf, | | Approximate Interval Between Onset and Death |
| , | e executed ian end uriel-transit | i Examiner | b . | | consequence of): | | | | | | |
| יחח אחם | eath certificete be executed ettending physician end for use es the buriel-transit | an/Medical | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| | the etter the otter hed for u | sici | Part II. Other significant conditions contributing to death but | not resuiting in | n the underlying caus | se giv | en in Part I. | 23b. Dld t | obacco use co | ntribute to | the cause of death? |
| | tac pa | Physician | ALCOHOLISM | | | | | 101 | es 2□ No | 3 Prob | ably 4 Onknow |
| | Se de | by | 7.5.0110010111 | | | | | | | | |
| 10001 | v requires been sign should be | Completed | | | | | | 24a. Was a | | ava | re autopsy findings iiable prior to |
| | 2 s 5 | npie | | | | | | | | of d | npietion of cause leath? |
| | The page | Col | | | | | | 1 X Y | es 2 No | 15 | Yes 2□ No |
| o Alla | ician: The certificate rector, pag | Be | 25. Was case referred to medical examiner? | | | | 26. Place of Deat | h (Check only o | 7a) | | |
| 5 | Physician: this certific ral director, | ဥ | 1 Yes 2 No Hospital: 1 ☐ Inpatient | | | Oth | 4 Intersing Ho | me 5 X Resid | | |) |
| | nding P ath. r: After t | Certification: | 27. Manner of Death 1 Matural 5 ☐ Panding 28a. Data of Injury (Month, Day Y | | | . Injur Wor | | 28d. Describe h | ow injury occur | red | |
| | Per a | cat | 2 Accident investigation 3 Sulcide 6 Could not be | | М | | Yes 2 □ No | 004 1 | | | 0-1-1 |
| | Direct in by | it a | 4 Homicide datermined 28a. Place of Injury building, etc. (| Specify) | rm, streat, factory, o | mica | | 28f. Location (S City or Tow | | er or Hurer | House Number, |
| • | filled | edicai Ce | 29a. Cartifier (Check only one) 29 Medical Examinar: On the basis of real and manner state | xamination and | , death occurred at t | ha tin | na, data and place, pinion, daath occur | and due to the c | ausa(s) and ma late and place, | annar as str | ated. tha cause(s) |
| | To the Howithin 2 Within 2 To the Fu completely | Med | 29b. Signature, and title of certifier | D | 29c L | icens | e number | | 29d. Date signe | d (Month. I | Dev. Year) |
| | - 3 - 8 | | Matterna Allo | 11 | | | | | FEBRUA | | |
| , | L | | 30. Name and address of person who completed cause of deal | th (florn 23a) | (Type, Print) | U | .C.M.E. | | EDKUA | IVI O | , 1950 |
| _ | | | MARIO F. GOLLET JR M. | HO / | , | St | reet. Ba | altimo | ce, Ma | rvla | nd 21201 |
| | Sta | ite | 31. Data filed (Month, Dey, Year) 32. Registrar's | s Signature | | | | | , | | T DIEVI |
| | Regist | ar | FEB 1 4 1996 Aui d | hurden K | ardall | | | | | | |
| | | - | | | | | | | | | |

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| | | | | State of Man | | artment of F tificate of | | | jiene 9 (| 03 | 953 |
|--------------|---|-----------------|--|--|--|---|---|---|------------------------------------|---|--|
| | Physic /Medi | | | ANG 6 | 14 | | | 2. Dete of Deer | Dey 8 | Vans | Dilloum |
| | Exami | | 4a. Fecility Name (If not institution, give Howard County Ger | | - 21 | | 4b. City, Town, or L Columbi | | 4c. County | of Death rd Count | +37 |
| f | Funeral Director | | 5. Sociel Security Number 6. Sociel Security Number 8. Sociel Security | | n yrs. last birthday) | If Under 1 Yeer Months Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Birth (Month, Dey February | | | Stete or Foreign |
| | faryland show | ٥٢ | Usuel Residence of Decedent 10e. Stete 10b. County Maryland Howard C | county | oc. City, Town or Lo COlum | Town or Location Columbia | | | | | side City Limits |
| | 3a or 28a- | il Director | 10e. Street end Number 6436 Cardinal Lane | 2 | | 10f. Zip Code 21044 | | 1 | 0g. Citizen of V USA | | |
| 020 | n 72 hours after death with the Maryland "natural", or flems 23s or 28=4 show solical Examiner route be notified at | by Funeral | 11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Detes; | 11 | Was Decedent of H f Yes, specify Cube | Ilspanic Origin? (Sp en, Mexican, Puerto Specify: | pecify Yes or No- Plican, etc.) | Bled | e - American Ind ck, White, etc. | fian, |
| 21215-0020 | C 8 | Completed | 15. Decadent's Ed (Specify only highest grad Elementery/Secondery (0-12) | Education 16 rade completed) College (1-4or 5+) | | lent's Usuel Occup kind of work done DO NOT use retired litary | etion during most of world) | ring | | usiness/Industry | |
| Maryland 2 | be filed ntal Hyg od other event, | To Be Co | Jue Shen Wu Shi | | | e (First, Middle, I | | | =1 timeirc | | |
| Man | and and | | 19e. Informant's Neme/Reletionship (7 | | | | end Number or Ru | | | |) |
| Baltimore, N | os 1 an of Heal Item 2 other | | Mr. En-Shinn Wu/ S 20e Method of Disposition 1 □ Diria 2 □ Cremetion 3 □ | | 6436 Cardinal Lane, Col Ob. Plece of Disposition (Name of cemetery, cremetory or other piece) | | | | | tete | |
| | permit. Page Department of Important: If any injury or once. | | 4 Donation 5 □Other (Specify 21 Signature of Funeral Service Licens | | Crestlawn | | | 2-12-96 | Marri | ottsvil | le, MD |
| Ba | Departme Importan any injur | | blankle | Sul | 22 | . Name end Addre Slack 1 | ssorrecounty Funeral H | lome, P. | Α. | | |
| 68760, | Physician polymerate process of a physician and physician and physician are the burial-itansity. | edical Examiner | In Plat1. Enter the disease, or only of nock, or heart feiture. List only of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. Due | e to (or es a consequence of to (or es e consequ | uence of): | wke) | | 1 | Inten | oximate val Between of and Deeth Ywar Y |
| Вох | death certific e attending pl od for use as f | Physician/M | | | | | | | | | |
| s, P.O. | requires that the de een signed by the hould be detached | by Physi | Pert II. Other significant conditions co | | | nderlying cause giv | en in Pert I. | 23b. Did to | | 3 ☐ Probably | 4 Unknown |
| Records, | aw 2 s b | Completed | | | | | | 24a. Wes a perform | | 24b. Were aur eveilable completion of death? | prior to on of cause |
| | F ag | | 05.11 | | | | | 1 🗆 Ye | -1 | 1 ☐ Yes | 2 No |
| Vita | Physician: this certific ral director, | To Be | 25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☑ No | Hospitel: | 2 ER/Outpatien | 1 3 DOA Oth | 28. Place of Dee | th <i>(Check only on</i> ome 5 ☐ Reside | | or (Specify) | |
| ion of | D 2 E | | 27. Menner of Deeth 1 Neturet 5 Pending 2 Accident investigation | 28e. Dete of Injury (Month, Dey Ye | 28b. Time of | 28c. tnjur Wor | | 28d. Describe ho | | | |
| Division | tal or Attendir rs after death. al Director: Al led in by the fu | Certification: | 3 Suicide 8 Could not be 4 Homicide determined | 28e. Pleca of Injury building, etc. (S | At home, ferm, stre Specify) | eet, fectory, office | | 28f. Location (St City or Town | | er or Rural Rout | e Number, |
| (| Fund Fund | edical | 29e. Certifier 1 Sertifying Phy (Check only one) 2 Medical Exami | elclan: To the best of m ner: On the besis of exa end menner steted | aminetion end/or inv | occurred et the tin estigetion, In my o | ne, dete end plece, plnion, deeth occur | end due to the co red et the time, d | euse(s) end me ete end place, e | nner as stated. end due to the co | ause(s) |
| | 0 1 2 S | M | 29b. Signeture end title of certifier | ~ | | 29c. Licens | | | , | d (Month, Dey, Y | 4 |
| , | | | 30. Neme and address of person who c | ompleted cause of deeth | (Item 23e) (Type, I | Print) | | | 4/) | 2/96 | P |
| | Sta | te | 31. Dete filed (Month, Dey, Year) FFR 1 A 100C | 32 Registrar's | Signature | 110 | 11045 | b | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | ils certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | on, or removal. | ne medical examiner must be notified at once. |
|--|---|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE REGISTRAR | ATE OF MARYLAI | ND / DEPART | MENT OF I | HEALTH AND | MENTAL HYGIEN | | | | | |
|---------------|--|---------------------------------------|--|--------------------|-----------------------------------|---|----------------|-------------------------------------|--|--|--|
| 7 | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | NAOMI | м. С | M. WACHTER | | | | 12 96 | 3155 PM | | | |
| - | 4. SOCIAL SECURITY NOMBER 5. SE | 6. AGE (In | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8.1 | BIRTHPLACE (State or Foreign | | | |
| | | M 2 7 F | 82 YRS. " | ONTHS DAYS | HOURS MIN. | (Month, Day, Year) 05 01 13 | | country) aryland | | | |
| - | 9e. FACILITY NAME (If not institution, give street en | d number) | | b. CITY, TOWN | OR LOCATION OF D | | | TY OF DEATH | | | |
| 6 | JOHNS HOOKINS GERIATRICS CENTS GALTEMORE N/A | | | | | | | | | | |
| EC | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY | TOWN OR LOCA | TION | | | 10d. INSIDE CITY | | | |
| DIRECTOR | Md. N/A | | | timore | | | LIMITS? | | | | |
| | 10e. STREET AND NUMBER | | | f. ZIP CODE | | 145 YES 2 NO | | | | | |
| FUNERAL | 3412 Dillon Street | | | | 21224 | | USA | | | | |
| 5 | | AS OECEDENT EVER IN U | I.S. ARMED | 13. WAS DEC | ENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No.— 14. | RACE — American Indian, | | | |
| ВУ | 1 Never Married 2 Merried 3 Widowed 4 Divorced | ORCES? 1 YES YES, GIVE WAR OR DATE | Z LANO ES | | ecify Cuban, Mexice 2 1 NO Specif | en, Puerto Rican, etc.) | | Black, White, etc. Specify: | | | |
| | | | | | | | I M | White | | | |
| 1 | 15. DECEDENT'S EDUCATION (Specify only highest grade comple | (ed) | 6a. OECEDENT'S US (Give kind of wor life. Do NOT use | k done during me | | 16b. KIND OF BU | SINESS/INDUST | TRY | | | |
| 2 | Elementary/Secondary (0-12) Colid | ege (1-4 or 5+) | House | 138 | | At Ho | ome | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | 110450 | WOLK | I MOTHER'S NA | ME (First, Middle, Meiden | | | | | |
| | Leonard Heineman | | | | | ne Cumber] | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street of | | Route Number, City or Tow | | tel | | | |
| 임 | Yvonne M. Miller | | | | | ille,Orego | | | | | |
| | 20e. METHOD OF DISPOSITION 1 | | LACE AND DATE OF | DISPOSITION (N | | | CATION — City | | | | |
| | 4 Donation 5 Other (Specify) | Carriota | ery, cremetory or other Oak Lawn | | erv 2-1 | 14-96 Eas | stwood | , Md. | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | :A | | | D ADDRESS OF FA | CILITY | | | | | |
| | I Charle D. | Jeiler | | | | eiler ¢&Sor .ng Street | | Ma | | | |
| | 23. PART I. Enter the diseases, or compli- | cetions thet ceused ti | he death. Do not | enter the mo | de of dying, suc | h aa cerdlec or reapi | ratory arrest, | Approximate | | | |
| | ahock, or heart failure. List or IMMEDIATE CAUSE (Fine) | nly one cause on eacl | h line. | | | | | Interval Between Onset and Death | | | |
| | disease or condition resulting in death) | SOND | es | | | | | | | | |
| | OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| Z | Sequentially list conditions, b. | mittag | | enal | Celoce | 30 | | | | | |
| Ĕ | DUE TO (OR AS A CONSEQUENCE OF): til any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury C. | DUE TO (OR AS A CO | ONREQUENCE OF | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | DOE TO (OH AS A CO | ONSCOUENCE OF): | | | | | | | | |
| | d | | | | | | | | | | |
| A | PART II. Other algnificent conditions cont | ributing to death but | not resulting in | tha underlyin | ceuse given in | Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS | | | |
| EDIC | Severe hypocal | Gemeiner | use ! | ciforay | ed Olas | 21 1 TYES 2 | | COMPLETION OF CAUSE OF DEATH? | | | |
| ¥ | Supraventilieglan | | | <u> </u> | | | ^ | 1 - YES 2 NO | | | |
| ÿ | DID TOBACCO USE CONTRIBUT | | | □ NO □ | UNCERTAIN | V 🗆 | | | | | |
| ੂੰ [| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER | | | | | | | | | | |
| PHYSICIAN: | | npatient 2 ER/Outpatie | ent 3 DOA 4 | Nursing Hom | | 8 Other (Specify) | | | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME (| Y WC | RK? | 28d. DESCRIBE HOW I | NJURY OCCURE | ED | | | |
| à l | 2 Accident Investigation | 8e. PLACE OF INJURY — | At home form of a | | rES 2 NO | *** ********** | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | building, etc. (Specify) | At Home, term, sere | et, factory, offic | | 281. LOCATION (Street a City or Town, State) | nd Number or R | lural Houle Number, | | | |
| | 29e. CERTIFIER | | | | | | | | | | |
| COMPLET | (Check only 1 CERTIFYING PHYSICIAN: To | | | | | | | | | | |
| ႘ | one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end manner es stated. | | | | | | | | | | |
| # I | 29b. CONATURE AND TITLE OF CERTIFIER | | | | OUTDO | BER | 29d. DATE SIG | GNED (Month, Day, Year) | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COME | PLETED CAUSE OF DEATH | (ITEM 97) (Sma A | ine) | 100 | | di | 112/96 | | | |
| | The state of the s | DEATE | · Wiem 21) (Nype, Pf | nn) | | | | | | | |
| | 31. DATE FILEO (Month, Dey, Year) 3 | 2. REGISTRAR'S SIGNATU | JRE | | | | | | | | |
| | FEB 1 4 1996 Juli A | wedgen Paul . | t | | | | | | | | |
| | | A . A | | | | | | DHMH-16 Rev 1/89 | | | |

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TO THE EXPLOYER MEDICAL TO INVESTIGATION OF PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT | OF HEALTH AND MENTAL | HYGIENE |
|--------------------------------|----------------------|----------|
| CERTIFICATE | OF DEATH | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | | | | HYGIENE REG. NO. | | | | | |
|--|--|---|--|----------------------------|---|--------------------------------------|-------------------------------|----------------|------------------|--|-------------|--|
| | 1. OECEOENT'S NAME (First, Middle, Last) GEORGE | | WATSON | | | 2. DATE OF MONTH FEB | | 1996 | AR | TIME OF OEAT | A M | |
| | 4. SOCIAL SECURITY NUMBER 212-84-0571 | 1 X M 2 🗆 F | 28 YRS. MO | UNDER I YEAR NTHE DAYS | IF UNDER 24 HRS. HOURS MIN. | Septem | Day, Year) | 1967 M | ountry) aryla | CE (Siete or Fo | reign | |
| TOR | 98. FACILITY NAME (If not Institution, give str University of Maryland RESIDENCE OF DECEMENT | | 96 | Baltimo | R LOCATION OF OR | N OF OEATN 9c. COUNTY OF OEATN N/A | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | ltimore | ION | 1 | | | | | NO | | | |
| | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | | 10g. CITIZEN | | COUNTRY? | | |
| FUNERAL | 407 Waveland Road | | | | 21228 | | | U.S | | | | |
| B⊀ | 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEOENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2X NO | If yes, spi | ENOENT OF NISPAR belty Cuban, Mexica 2 NO Specifi | in, Puerto Ric | | | Black, WI | American India hita, etc. hite | ın, | |
| COMPLETED | 15. DECEDENT'S EOUC. (Specify only highest grade of Elementary/Secondary (0-12) | completed) College (1-4 or 5 +) | t6a. DECEDENT'S USI (Give kind of work life. Do NOT use re | done during mo- tired.) | st of working | | | INESS/INDUSTI | | | | |
| MP | 12. FATNER'S NAME (First, Middle, Last) | 1+ | Electronics | Technic | ian 18. MOTNER'S NA | | ederal | Govern | nent | | | |
| BE CC | George Edward Watso | on, Sr. | | | Rebecca | a Fris | ki | | | - | | |
| 10 | George Edward Watson, Sr. (Father) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Waveland Road Catonsville, Maryland 21228 | | | | | | | | | | | |
| | 20b. METNOO OF DISPOSITION 1 M Burial 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cameter), cremetery, cremetery or other place) MEADOWRIDE OF SIMPRALES FROM STATE 20b. PLACE AND DATE OF DISPOSITION (Name of cameter), cametery, cremetery, cremetery or other place) MEADOWRIDE OF SIMPRALES FROM STATE 20b. PLACE AND DATE OF DISPOSITION (Name of cameter) 20b. PLACE AND DATE OF DISPOSITION (Name of cameter) 20b. PLACE AND DATE OF DISPOSITION (Name of cameter) 20b. PLACE AND DATE OF DISPOSITION (Name of cameter) 20b. PLACE AND DATE OF DISPOSITION (Name of cameter) 20c. LOCATION — City or Town, State 2 | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY. Leroy M. & Russell C. Witzke Funeral Home 1630 Edmondson Avenue Catonsville, Maryl | | | | | | | | | s and 2122 | 18 | |
| | 23. PART I. Enter the diseases or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heert feiture. List only one cause of each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) One SEPSIS OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST b. INFECTED PERITONEAL DIALSIS CATHETER OUE TO (OR AS A CONSEQUENCE OF): c. RENAL FAILURE DOE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | |
| EDICAL | PART II. Other algolficant conditions | contributing to death b | ut not resulting in t | he underlying | cause given in | | PERFOR | MEO? | AVA COI OF | RE AUTOPSY FI NLABLE PRIOR MPLETION OF (DEATN? | TO CAUSE | |
| PHYSICIAN: M | DID TOBACCO USE CONTR | IBUTE TO CAUSE O | F DEATH YES | □ NO K | UNCERTAI | N 🗆 | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF OEATH (| Check only one) THER: | | | | | | | | |
| 14S | 1 TYYES 2 NO 27. MANNER OF OEATN | 1 Inpatient 2 ER/Outp | | ☐ Nursing Nom | ● 5 ☐ Residence | , | | JURY OCCURE | · n | | | |
| ВУ Р | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUR | y wo | RK? 'ES 2 NO | 200. 5240 | MDE NOW II | | | | | |
| | 3 Suicide 6 Could not be 4 Nomicide determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, lerm, stre- city) | et, factory, oNic | | | TON (Street a Town, Stete) | nd Number or R | ural Route | Number, | | |
| COMPLETED | one) | CIAN: To the best of my know | | | | | | | use(a) an | d menner aa a | stated. | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | on 1 | 4.D | | 29c. LICENSE NU D4510 | | | | | | | |
| 2 | 30. NAME AND AGORESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BARRINGTON NELSON 22.S GREENE ST BALTIMORE, MD #21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) FEB 1 4 1996 July Charles Control of the Contr | | | | | | | | | | | | |

Physician /Medical Examiner

physician as the burial Physician/Medical signed by the at d be detached for à Completed peen certificate Be 10 this Certification: After Director: in by To the Hospital within 24 hours a To the Funeral Completaly filled

The law requires that the death certificate be axecuted

or Attending Physician:

Hospital

death.

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onsel and Death immediate Cause (Finel disease or condition resulting in death) PULMONARY EMBOLI Due to (or es a consequence of): FRACTURED LEG Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 25. Was cese referred to medice 26. Piece of Deeth (Check only one) examiner? 1XXes 2 No Hospital: 1 ☐ Inpatient 2XXP/Outpatien1 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28b. Time of injury 26d. Describe how injury occurred 28a. Date of injury (Month, Day Year) 28c. injury at Work? 1 Netural 5 Pending investigation 1 ☐ Yes 2/1X No 2 Accident UNKNOWN UNKNOWN SUBJECT FRACTURED LEG 6 Could not be 3 Suicide 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide UNKNOWN Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basia of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier 29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Dey, Year)

FEBRUARY 11, 1996

State Registrar

MAKEN 111 Penn Street, Baltimore, Maryland 21201 LOCKE 31. Date filed (Month, Day, Year) FEB 1 4 1996

use of deeth (item 23a) (Type, Print)

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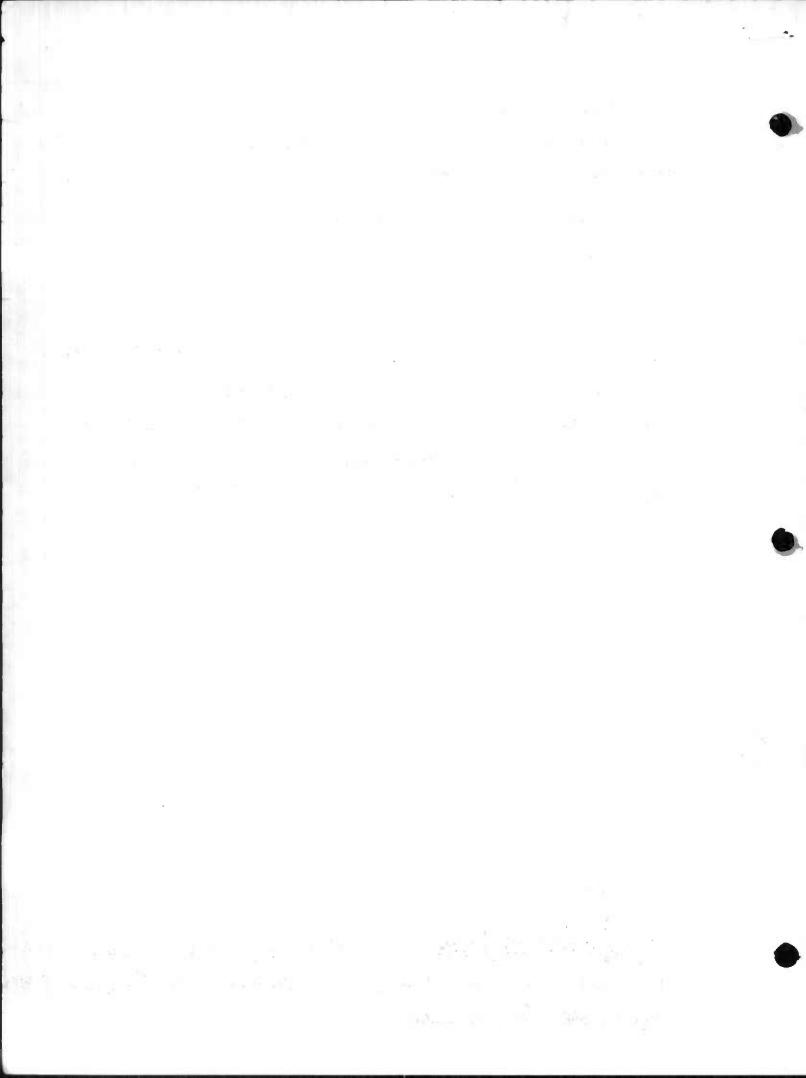
Item7 2-14-96 FilmG732 W.H.Per F/H Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey 12,1996 **Physician** Michael 1 Welsh February 8:30 A.M /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Harford County 1205 Hanson Road Edgewood 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Year Months Deys If Under 24 Hrs. 7. Age (In vrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** Hours 15 M 2□ F 212-05-3878 Director May 4,1911 84 Maryland Usual Residence of Decedant with the Maryland 10a. Stete 10c. City, Town or Location Nem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be not fired at 10d. Inside City Limits Md. Baltimore City N/A Director Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 6205 Walther Avenue 21206 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Haalth and Mental Hygiena. Important: If flem 27 Is marked other than "natural", or flems 23, any Injury or other traumatic event, the Medical Examiner mast Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specity Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Maritei Stetus 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Storm Window Company 12th_Grade Salesman 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be P Richard John Welsh Mary Veronica Kane 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Elena Ann Welsh 6205 Walther Avenue, Baltmore, MAryland-21206 20b. Place of Disposition (Name of cemetary, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removel from Stele 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 2/15/96 Baltimore, Maryland 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility 6415 Belair Road John C. Miller, Inc. Baltimore, Maryland-21206 23a. Part l Entar the disease, or complications that baused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical immediate Cause (Final diseese or condition resulting in deeth) Examiner Dua to (or as e consequence of) Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasuiting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 88 usa Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown d by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Records, þ Completed 24a. Wes an eutopsy parformed? 24b. Were autopsy findings aveilable prior to 8 completion of cause of death? 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the Iuneral director; Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) varding 1 ☐ Yes Othar: 4□ Nursing Home 5□ Residence P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) Home Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occorred 28c. injury et Work? 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be datermined 3 ☐ Suicide 28a. Piece of Injury - At homa, ferm, street, fectory, office building, etc. (Spacify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide 29a. Certifier Cartifying Physictan: To tha best of my knowladga, death occurred et the time, data and piece, and due to the cause(s) and mannar as stated. Medical → Contriging Physician: 1 of the best of my knowledge, death occurred at the time, date and piece, and do to the cause(s) and manner: on the basis of axaminetion end/or investigation, in my opinion, daeth occurred at the time, date and piece, and due to the cause(s) and menner steled. 29b. Signature and title 29c. License number 29d. Deta signed (Month, Day, Year) 30. Neme end addre cause of daeth (item 23e) (Type, Print) Business Of Way #102 308 Stom man 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State the develor Radall 1996 Registrar FFR 1

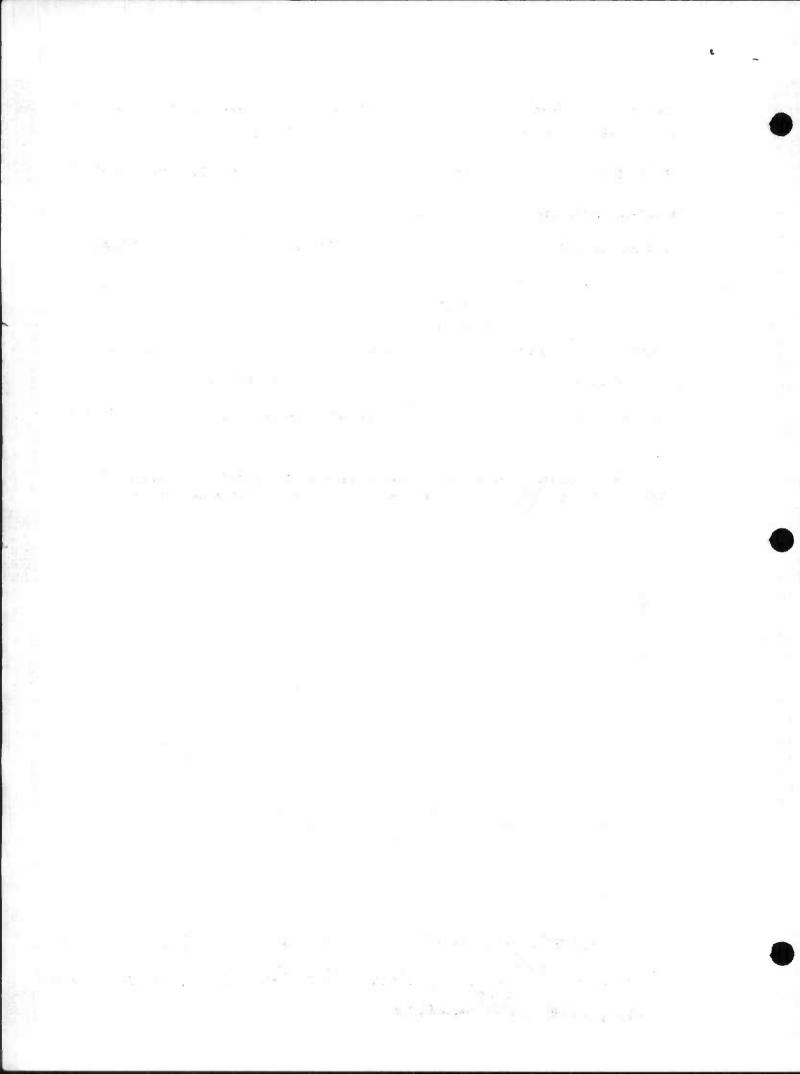
DHMH 16 Rev 6/95



Item1 2-15-96 FilmG732 W.H.Per Anatomy B.
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| riease Type of Fillit III black ilidelible lik. Assule All Copies Are t | egible. | |
|---|---------|-------|
| State of Maryland / Department of Health and Mental Hygiene | 96 | 03958 |
| Cortificate of Dooth | 20 | 00000 |

| | | | | | (| Certificat | e of | Death | | | Reg. No. | 0 0 | 0000 |
|--|--|----------------|--|--|----------------------------------|--|--|-----------------------|---|--|--------------------------------|--------------------------------------|---|
| | Physic | ian | 15 4. | rno Joseph | | | | | | 2. Data of De Month | ath Day | Yaar | 3. Tima of Death |
| | /Medi Examir | | 4a. Facility Nama (If not institution, give Johns Hopkins Bau | a street and number) | 15. | 1 va € | 20 | 4b. City, To Balti | wn, or La | cation of Dead | | 96 y of Death | 7:55 pm |
| - | Funeral Director | | 219-12-8388 | ax 7. Aga (| (In yrs. last birth | Months | 1 Yaa Days | | 24 Hrs. Min. | 6. Data of Bin (Month, Da Oct. 1 | th y. Year) 1, 1921 | 9. Birthp Coun Mary | eleca (Stata or Foreign Cand |
| | Marylend a-f show utled at | ctor | Usual Rasidance of Dacedant 10a. Stata 10b. County Maryland Baltimon | | Oc. City, Town | | | | | | | 1 | 0d. Insida City Limits 1 ☐ Yas 2 No |
| 21215-0020 d within 72 hours efter death with the Mandend | th with the 23a or 28 | al Director | 10e. Street and Number 38 GLenwood Road | | | 10f. Zip | | 1221 | | | 10g. Citizan of | What Cour U.S.A | ntry? |
| | De filed within 72 hours after death with the Maryler ntal Hygiene. ed other than "natural", or fleme 23a or 28e-f show event, the Maxical Evariner must be notified at | by Funeral | 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Ev Armad Forcas? 1 [X] Yas 2 □ No If Yas, Giva Yaar or Datas: | | 13. Was Deced If Yas, special 1 ☐ Yas | cify Cul | ban, Maxicar | n, Puarto | ecify Yas or No Ricen, atc.) | | ce - Amaric ick, Whita, fy: Wh | |
| | od within 72 h giene. er than "natu t, the Medical | Completed | 15. Decedant's Ec (Specify only highast gra Elementery/Secondary (0-12) UNIZNOWN | ducation 16a. Deced (Giva life. L | | Giva kind of wo | dant's Usual Occupation kind of work dona during most of workir DO NOT usa retired) OWM | | | ing | 16b. Kind of Business unknow | | dustry |
| Maryland | should be filed and Mental Hygic marked other umatic event, II | To Be (| 17. Fathar's Name (First, Middla, Last) Abramo Barnabae | | 1 | | | | | ma (First, Middla, Maidan Sumama) Falconi | | | |
| more, | 0 0 7 6 | | | | | | | B-Esse. | Routa Number, City or Town, Stata, Zip Coda) 8-Essex, Maryland 21221 | | | | |
| | Page mt.H | | 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ② Donation 5 ☐ Other (Specify | | 20b. Placa of E cematary, | Disposition (Nar crematory or o | na of thar pl | ace) | | Data | 20c. Location | - City or To | own, Stata |
| Balt | permit. Pa Departmen Important any injury 2058. | | 21. Signalatio of Funaral Sancos Liour Robot | Deec s | 2/18/4 | Rm.B026 | -Ba | ltimor | re, 1 | larylan | d 2120 | ore S 1-155 | treet |
| | Physician /Medical | | Part 1. Entar the disease, or composite the control of the control | plications that caused thona cause on each line. a. Adems | | | | | | / | | | Approximete Intarval Batween Onsat and Death |
| | Examiner | ner | disaasa or condition resulting in daath) | a. TICENS | ua to (or as a co | nsequence of): | | 1100 | 1 | 1 224) | vor sp | 146 | Joan |
| , 0, | e execute lan end urial-trans | I Examiner | Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Ceuse (Disaesa or Injury c. | | | | | | | | | | |
| Box 68760, | eath certificate be executed ettending physician end I for use as the burial-transit | an/Medical | rasulting in death) Last Dua to (or as a consaquance of): | | | | | | | | | | |
| P.O. | requires that the death seen signed by the etter hould be detached for u | by Physician/ | Part II. Other significant conditions of | ontributing to death but | | | | 0 | | | tobacco use co Yea 2 No | | the cause of death? bably 4 Monknown |
| Vital Records, | sw requisite been 2 should | Completed b | | | | | | | | 24a. Was | an autopsy rmed? | av | ara autopsy findings alleble prior to mpletion of cause daath? |
| al B | The ate h | | | | | | | | | 10 | Yas 20 No | 10 | Yas 285No |
| 5 | Physician: r this certific ral director, | o Be | 25. Was case referred to medical axaminar? 1 Yas 2 Kno | Hospital: | 0 EB/0to | attant all Do | . 0 | ther: | | h (Check only o | | /C if | |
| on of | ding Phys h. After this funeral di | tion: To | 27. Mennar of Death 12 Natural 5 ☐ Panding | 26a. Dete of Injury (Month, Dey Y | 2 ☐ ER/Outp 26b. Tin (ear) | | 8c. Inju | | | | dance 6 GOt how Injury occu | | y) |
| Division of | f or Attending after deeth. Director: After d in by the fune | Certification: | 2 Accidant invastigation 3 Suicide 6 Could not be 4 Homicide data mined | | - At homa, farm (Specify) | n, streat, factory | | | | 28f. Location (: City or To | | ber or Rura | il Routa Number, |
| | To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune | edicai C | | ysician: To the best of rainer: On the basis of an and mannar state | camination and/ | | | | | | | | |
| | To th within To th comp | Me | 29b. Signatura and titla of certifier Penolel 7 | S73,1 | 1.D. | | | sa number | 6 | | 29d. Data sign. Februa | ed (Month, | Day, Year) 5, 1996 |
| | | | 30. Nama and address of person who described to the second of the second | completed causa of daar | th (Itam 23a) (T) | ype, Print) | W | 1/1 | -or a | 1 Dr. | Apt. F. | Balt. | 5, 1996 more MO2122 |
| | Sta Registr | | 31. Deta filed (Month, Day, Yaar) FEB 1 5 1996 | 22. Registrar's | Signature | | | | | | , | | |



Diane

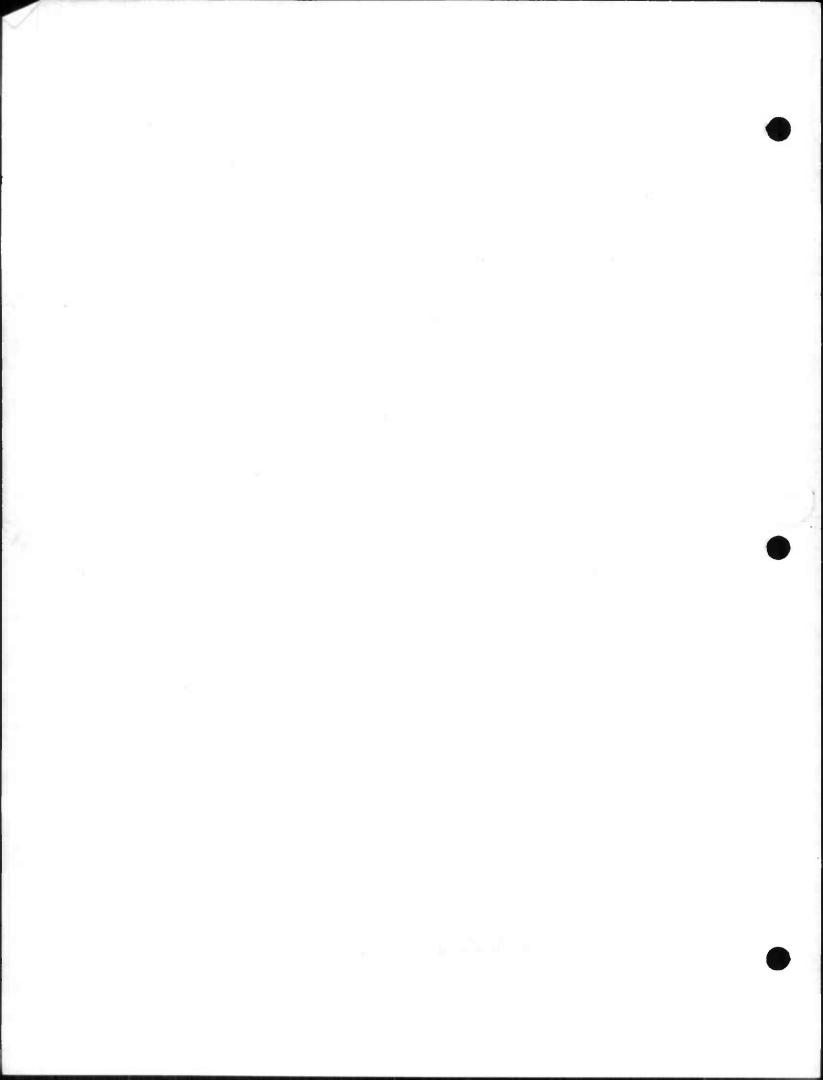
| HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending |
|---|
| completely filled in by the tuneral di |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygliene prior to burial, cremation, or removal. |
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | MENT OF H | | MENTAL HYGIEN | | | | |
|---------------|--|---|---|---------------------|--------------------|--|--|---------------------------------------|--|--|
| Y. | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| 77 | | Robert Os | car Burkl | hardt | • | January | 21. 199 | | | |
| | 4. SOCIAL SECURITY NUMBER | | yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | Co | RTHPLACE (State or Foreign untry) | | |
| | 216-12-9952 | 1 X M 2 □ F 7. | 4 YRS. | | | Sept. 18 | ,1921 | West Virginia | | |
| oc . | 9a. FACILITY NAME (If not institution, give s | | 1 | | R LOCATION OF DE | ATH | 9c. COUNTY O | | | |
| DIRECTOR | 17 Waterview Romesidence of decedent | jaa | | L | undalk | | Bal | timore | | |
| REC | 10s. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCATI | | | 10d. INSIDE CITY LIMITS? | | | |
| | Maryland | Baltimore | | | Dunc | dalk | | 1 TES 2 NO | | |
| RAL | 100. STREET AND NUMBER | , | | 10f. | ZIP CODE 2122 | 20 | 10g. CITIZEN OF WHAT COUNTRY United States | | | |
| FUNERAL | 17 Waterview Road | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13 WAS DECE | | Z Z IC ORIGIN? (Specify Ye | | ACE — American Indian, | | |
| | 1 Never Married 2 X Married | FORCES? 1 X YES IF YES, GIVE WAR OR DA | 2 NO | If yes, spe | | , Puerto Rican, atc.) | 8 | leck, White, etc. | | |
| ВУ | 3 Widowed 4 Divorced | | WWI | 1 | aye no openy. | | | white | | |
| TEC | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16s. DECEDENT'S U (Give kind of we life. Do NOT use | ork done during mos | N t of working | 16b. KIND OF BU | F BUSINESS/INDUSTRY | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | | Room Cle | пЬ | Sto | el Indu | stru | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | 1002 | KOOM CAE | | ME (First, Middle, Maider | | 570 tg | | |
| BE C | Harry Burkhard | t | | | | Eleanor St | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 1 | | | loute Number, City or Tox | | | | |
| F | Mrs. Nancy E. | | | | | Dundalk, M | | v | | |
| | 20a. METHOD OF DISPOSITION 1 (X Burlel 2 Cremetion 3 Removel from State 4 Donation 8 Other (Specify) Donation 1 Other (Specify) Donation 2 Donation Removel from State Meadowriage Me. Pk. 1/25/1996 Donsely, Manyle | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Meadowridge Me. PR. 1/25/1996 Vorsey, Mary 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, | | | | | | | | | |
| | + Com PC | Danon_ | _ | Duda-1 | Ruck Fund | eral Home | of Vund | alk, Inc. | | |
| | 23. PART i. Enter the diseases, or o | complications that caused | the death Done | | | . Dundalk | | and 21222 | | |
| | shock, or heart failure. | Liet only one cause on ee | ch line. | or union the mo | ia or dying, addi | res cardiac or resp | metory arrest, | interval Between Onset and Death | | |
| | iMMEDIATE CAUSE (Finel disease or condition | Eneur | noma | | | | | 2 days | | |
| | resulting in death) e. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Z | Sequentially list conditions, | b | | | | 0 | | II . | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| FIC | | | | | | | | | | |
| FRE | reaulting in death) LAST | d | | | | | | | | |
| L C | PART ii. Other aigniticant condition | ne contributing to deeth br | it not resulting in | the underlying | cause given in | Part i. 24a, WAS A | NAUTOPSY | 24b. WERE AUTOPSY FINDINGS | | |
| - 60 | pyperte | usion, a | ortie | anen | ryan | | RMED? | AMILABLE PRIOR TO COMPLETION OF CAUSE | | |
| MEDIC | Spatter 1 | Daralyse, | pepte | e ule | 2/ | | 2 0 100 | OF DEATH? | | |
| | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | F DEATH YE | S NO | UNCERTAIN | V 🗆 | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEAT | OTHER: | | | | | | |
| KSI | 1 TYES 2 TO NO | 1 Inpatient 2 ER/Outpa | | 4 - Nursing Hom | | 8 Other (Specify) | | | | |
| РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME | JRY WO | RK? | 26d. DESCRIBE HOW | INJURY OCCURE | | | |
| ВУ | 2 Accident Investigation | 28e. PLACE OF INJURY | - At home, farm, at | | ES 2 NO | 281. LOCATION (Street | and Number or Ru | ral Route Number | | |
| 밀 | 4 Homicide 8 Could not be | building, etc. (Speci | | | | City or Town, State | | , | | |
| E | 29a. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of my knowl | edge, daath occurre | d at the time, date | and place, and due | to the cause(a) and mu | anner se stated. | | | |
| COMPLETED | cool only | ER: On the basis of exemination | | | | | | se(s) and manner as stated. | | |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIE | R / | /) | | 29c. LICENSE NUM | ABER | 29d. DATE SIG | NED (Mogth, Day, Year) | | |
| TO B | John . Co | nevay, M. | U. | | 0036 | , 26 | 1 / /2 | 4/96 | | |
| F | 30. NAME AND ADDRESS OF PERSON WI | 10 COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, | Print) | 01 - | 711 | | * | | |
| | 31. DATE FILED (Month, Day, Year) | 132 REGISTRAR'S SIGN | I CITAL | acery | .16 | DALtin | rope, | | | |
| | FFR 1 5 1996 | Jalin Davidson | Revell | V | | | | | | |
| | 1 1 2 330 | - - - - - - - - - - | | | | | · · · · · · · | DHMH-16 Rev 1/89 | | |
| | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 6876

| | FOR STATE REGISTRAR | STATE OF MAI | | MENT OF HEALTH AND CATE OF DEATH | ID MENTA | L HYGIENI REG. NO. | | | | | |
|---------------------|--|---|---|---|--|---------------------------------|-------------|---|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) CLARENCE | Ε. | BYNUM | | 2. DATE MONT Fe | | | PAR | 7:55 Pm | | |
| | 4. SOCIAL SECURITY NUMBER 216-42-2476 | 5, SEX 6. | | F UNDER 1 YEAR IF UNDER 24 HO ONTHS DAYS HOURS MI | RS. 7. DATE | OF BIRTH h, Day, Year) | 0. | | ACE (State or Foreign | | |
| NO BO | 90. FACILITY NAME (It not institution, give a Mercy Stella Ma | aris | .9 | Baltimore | 0 0 1 | , 011 | OF DEAT | OF DEATH | | | |
| IRECT | 10a. STATE 10b. COUNT | | | TOWN OR LOCATION | | | | Dd. INSIDE CITY LIMITS? X YES 2 NO | | | |
| RAL | 100. STREET AND NUMBER 3224 GWynns Fal | | Date | 101. ZIP CODE 21216 | 5 | | - | | OF WHAT COUNTRY? | | |
| BY FUNERAL DIRECTOR | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EX FORCES? 1 IF YES, GIVE WAR | YES 2 X NO | 13. WAS DECENDENT OF HI If yes, specify Cuben, M 1 YES 2 NO S | SPANIC ORIGII exican, Puerto pecify: | N? (Specify Yes Rican, etc.) | or No.— 14. | | American Indian, vhita, etc. Black | | |
| COMPLETED | 18. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 12th grade | CATION o completed) College (1-4 or 5+) | 16a. DECEDENT'S US (Give kind of wor life. Do NOT use i | k done during most of working retired.) | | Douglas | | | chool | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) Bennie Bynum 190. INFORMANT'S NAME (Type/Print) | | | Annie | s name (First, | Middle, Melden McClint | Sumame) | | | | |
| 5 | Willie Mae Bynur | n | 3224 G | Swynns Falls | arkwa | y Balt | imore | , Md | | | |
| | 20s. METHOD OF DISPOSITION 1 XX Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Completery, Green place), Green place of Completery, Green plac | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE **The state of Funeral Service Licensee **And Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 2121. | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| A L | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 27500 | | | | | | | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t YES 2 NO | | |
| IAN: N | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | RIBUTE TO CAUS | SE OF DEATH YES | | TAIN 🗆 | | | | | | |
| PHYSICIAN: MEDIC | EXAMINER? t YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 inpatient 2 El 28a. DATE OF INJ (Month, Day, | R/Outpatiant 3 DOA 4 | OTHER: Nursing Home 5 Reside OF 28c. INJURY AT WORK? | | or (Specify) HC | | | AT MERCY | | |
| ED BY | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | and Number or | Rural Route Number, | | | | | | | | |
| COMPLET | (Original Oriny | | | at the time, data and place, and in my opinion, death occured a | | | | | and menner es stated, | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D40480 Fig. | | | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5810 BEZAIR RD FERNANDO J. FERRU, MD BALTO, MD 21206 | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32, REGISTRAR'S | SIGNATURE | | | | | | | | |





Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death FEBRUARY 12, 1996 **Physician** Frank EDWIN BRADY 3:20 AM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Dete of Birth (Month, Day, Year) June 18, 1943 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F 52 219-40-6878 New Jersey Director Usuel Rasidence of Dacedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23e or 25a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 Breezy Hill Way 21030 USA 2 should be filed within 72 hours after death and Mental Hygiene. Funeral 12. Wes Decedent Ever in U,S. Armed Forcee? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 1 Tyes 2 Vietnam If Yes, Give Vietnam Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: white þ 3 - Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Systems Analyst Computer Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Reginald Franklin Brady is marked Catherine Marie Cummins 19e. Informent'e Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m William T. Brady/Brother 1905 Norman Rd. Glen Burnie, MD 21061 mmore, 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ØCremetion 3 ☐ Removel from Stete injury or Metro Crematory, Inc. 02/13/96 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 24 hours SEPSIS Examiner Dua to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest Dua to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Syndro 1 pers Physician/Medicai Due to (or es e consequence of): ed by the s Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown CABG, tegison by 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed peen has 1 ☐ Yes 2 ☐ No 1 Yes 2 PNo certificate Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Naturei 5 Pending death. 1 Yes 2 No invastigation 2 Accident after death Director: / 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29d. Dete signed (Month, Dey, Year) 29c. License number 1104 13 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - WSON MD 2120 4. 31. Dete filed (Month, Day, Year) York

32 Registrer's Signeture

State Registrar

1° . 4 102

maniferance (2) per m

| State of Maryland / Department of Health and Mental Hygiene 95 039 | | | | |
|--|-----------------------------------|--|--|--|
| Centificate of Death party | | | | |
| rieg, to. | me of Death | | | |
| Month Dev Year | | | | |
| (EDROAKY 12 1176) | :00 pm | | | |
| | BALTIMORE | | | |
| 5. Social Security Number 6. Sax 7. Age (In yrs. last birthdey) 85 Yrs. 1 Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Months Deys Hours Min. 1 Mary Lan MAR. 2,1910 MARYLAN | | | | |
| Usuel Residence of Decedent | | | | |
| | ide City Limits | | | |
| MARYLAND BALTIMORE BALTIMORE | Yes 2 No | | | |
| 10e. Street and Number 3409-A COURTLEIGH DRIVE 10f. Zip Code 21244 10g. Citizen of Whet Country? USA | | | | |
| 11. Marital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, Specify Cuban, Maxicen, Puerto Ricen, etc.) 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - American India Black, White, etc. 15. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 16. Race - American India Black, White, etc. 17. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 18. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) | | | | |
| 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working | ness/Industry | | | |
| (Specify only highast grada completed) Elementery/Secondery (0-12) 12 (Giva kind of work done during most of working life. DO NOT use retired) BROKER REAL ESTATE | | | | |
| 17. Father's Neme (First, Middla, Last) 18. Mothar'a Neme (First, Middla, Meiden Surnema) | | | | |
| ABRAHAM BLOCK SARAH ABRAMS | | | | |
| 19a. Informent's Neme/Relationship (Type, Print) MRS. SOPHIA BLOCK (WIFE) 19b. Meiling Aridress (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 3409 COURTLEIGH DRIVE BALTIMORE, MD 21244 | | | | |
| | | | | |
| 20a. Mathod of Disposition 1 \(\begin{align*} \text{ZION TIFERETH ISRAEL} \) 20c. Location - City or Town, Stet 20c. Location - City or Town, | | | | |
| 21. Signeture of Funerei Service Licensee 22. Nama and Address of Fecility | | | | |
| Cellensue Levenson SOL LEVINSON & BROS., INC. | _ | | | |
| 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Interventions of the cause on each line. | ximate al Between and Death | | | |
| Immediata Ceuse (Finel disease or condition resulting In death) e. CHRONIC OBSTRUCTWE PLUMONARY DISEASE 30 3 | COARS | | | |
| | | | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enfer undarlying Ceuse, Disease or injury c. | 1 | | | |
| Ceuse (Disease or Injury that Initiated evants rasulting In death) Lest Due to (or es e consequence of): | | | | |

Physician /Medical Examiner

Physician /Medical

Examiner

Completed by Funeral Director

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Engineer must be notified at

Baltimore, Maryland 21215-0020

as been signed by the attending physician and 2 should be detached for use as the burial-transit

Physician/Medical Examiner

Be Completed by

2

Medical Certification:

4 Homicide

29a. Certifier

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

Seq if an ceus Ceu thet rasu

Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. BRONCHOGENIC CARCINOMA

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No

24e. Was an eutopsy performed? 1 Yas 20 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Wes cese referred to medical examinar? 28. Plece of Daath (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred

28e. Deta of injury (Month, Dey Year) 27. Menner of Deeth 1 Neturel 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29b. Signeture end titla of certifier

12 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as stated.
2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end mennar stated. 29c. License number D45770

1 Yes 2 No

29d. Data signed (Month, Dey, Year) FEBRUARY 12, 1996

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

ROY IMPERIO DENNIS 5401 OLD COURT ROAD, RANDAILSTOWN, MD 21133

31. Dete filed (Month, Day, Year) FEB 1 5 1996

32 Redistrar's Signature

" had one of the sent of the

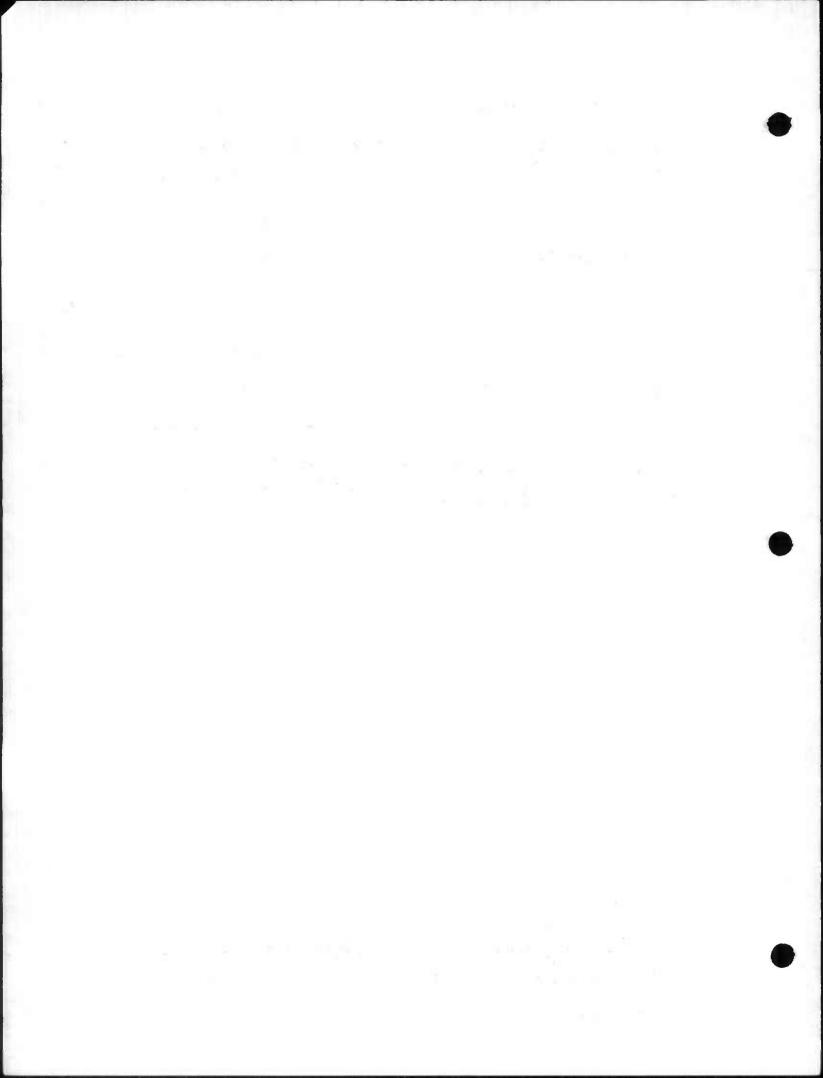
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 96 03963

| | | | | | | Ce | rtificat | e of | Death | 7 | R | eg. No. | | | |
|-------------------|--|----------------|---|--|-----------------|----------------------------|-----------------------------|----------------|-----------------|---------------|----------------------------------|-------------------------------------|-------------|--|--|
| | Diam'r. | | 1. Decedent's Neme (First, Middle, | Last) | | | | | | 1 | 2. Date of Deet Month | - | Year | 3. Time of Deeth | |
| | Physic /Medi | | Ruth N. Barnes | | | | | | | | Feb 12. | 1996 | 1 oai | 10:15 AN | |
| 0 | Exami | | 4a. Facility Name (If not institution, | give street end num | ber) | | | | 4b. City, To | | ation of Deeth | 4c. County | of Death | | |
| | | | 1037 Kingsbury | Road | | | | | Reist | ersto | wn | Ba1 | timor | · n | |
| | Funeral | | | . Sex 7 | . Age (in yrs. | lest birthdey | If Under | 1 Yeer Days | If Unde | | B. Dete of Birth (Month, Dey, | | | plece (Stete or Foreign | |
| 1 | Director | | 212-05-8942 | 1□M 2MF | 79 | Yrs. | MONTHS | Days | Hours | | ent 11, | | | | |
| | p | | Usuel Residence of Decedent | | | | | | | | | | | | |
| | how the | | 10e. Siele 10b. County | | 10c. Ci | ty, Town or L | ocation | | | | | | 1 | 10d. inside City Limits | |
| | o We | 양 | Maryland Baltim | ore | Re | isters | stown | | | | | | | 1 □ Yee 2 및 No | |
| | th th | Director | 10e. Street end Number | | | | 10f. Zlp | Code | | | 10g. Citizen of Whet Country? | | | | |
| 21215-0020 | 23a | Funerai [| 1037 Kingsbury | Road | | | | | 2113 | 6 | U.S.A. | | | | |
| | 80 | le l | 11. Meritel Status | 12. Was Decedent Ever in U,S. Armed Forces? | | | Was Deced | lent of I | Hispanic Or | rigin? (Spec | ify Yes or No- ican, etc.) | | e - Americ | can Indien, | |
| | within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f show to Medical Examiner must be notified at | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | | No No | | 1 ☐ Yes 2 | | | | out, oto., | Specif | | | |
| 5-0 | be filed within 72 hours hall Hygiene. Ind other than "natural", event, the Medical Exa | Completed | 15. Decedent's (Specify only highest | Education grede completed) | | (Give | edent's Usua kind of wor | rk done | during mo | st of working | 2 | 16b. Kind of B | usiness/In | dustry | |
| 121 | rithin ne. | m j | Elementery/Secondary (0-12) | College (1~ | 4or 5+) | life. | DO NOT us | e retire | ed) | | | | | | |
| 2 | 2 should be filed within end Mental Hygiene. Is marked other than summit event, the M | | 10 | | | Caret | eria | Wor | | | | A - 111 - 11 - 211- | | Schools | |
| an o | bo bo | Be | 17. Father's Name (First, Middle, La | st) | | | | | 18. Moth | ers Name (| First, Middle, I | | | | |
| 3 | Mer Mer | 2 | Samuel Eaton | | | | | | | | | | nown | | |
| Maryland | 2 sh end ls m | | 19a. Informant's Name/Reletionship | | | | | | | | Route Number | | | | |
| | f Health and Alerth and Martain 27 is marke other traumatic | | Elmer Barnes, Jr | ./Son | 1001 | | | | y Roa | d Reis | | | | d_21136 | |
| Baltimore, | H to H | | 20a. Method of Disposition Y⊠ Buriel 2 ☐ Cremetion 3 | ☐Removei from Si | late (| Plece of Disponentery, cre | metory or o | ther ple | | į | | 20c. Location - | City or To | wn, State | |
| | ant: | | 4 ☐ Donetion 5 ☐ Other (Spe | | Sta | blers' | Churc | h C | emete | ry 2/ | 15/96 _P | arkton | Mar | vland | |
| Sall | permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. | | 21. Signature of Funerel Service Lic | ensee | (0 | 100 | 2. Neme en | | | • | | | | | |
| ш | 205 2 3 | | a ala | - 10° | t(b) | 3.9 | Alan | Se: | ILZ, | Jr. Ft | meral | Home | 1 0 | 1011 | |
| | _ | | 23a. Part 1. Enter the disease, or co shock, or heert failure. List or | mplications thel ca | used the deat | h. Do not er | iter the mod | e of dy | ing, such as | s cardiec or | respiretory erro | Mary La | ina Z | Approximete | |
| | Physician | | SHOOK, OF HOOF IGHTS. LIST OF | y one cause on ee | Cillino. | | | | | | | | 1 | Onset and Deeth | |
| | /Medical | | Immediate Cause (Finel disease or condition | a. Ade | MA COL | Venas | 00.0 | /Ph | flu | n4 | | | 1 | | |
| ш | Examiner | | resulting in deeth) | a. // Q e | | or es a conse | | | 1 100 |) | | | | | |
| | D # | ne | | | | | , | | | | | | | | |
| | deeth certificate be executed e attending physician and ad for use as the burlel-transit | Examiner | Sequentielly list conditions. | b | Due to (c | or as e conse | quence of): | | | | | | 1 | | |
| Ó | an e | | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | | | | | | | | | | į | | |
| 68760, | ysicl he by | Medical | thet mitiated events | C | Due to (o | (or es a consequence of): | | | | | | | - | | |
| | ng ph as ti | Med | resulting in deeth) Lest Due to (or es a consequence of): | | | | | | | | | | i | | |
| Вох | attendin for use | | | | | | | | | | | | | | |
| | the atte | Physician | Pert II. Other eignificant conditions | contributing to dea | Ih bul not res | ulting in the | underlvina c | ause di | ven in Part | i. | 23b. Did to | bacco use co | ntribute to | o the cause of death? | |
| P. 0. | # 70 m | hy | 1 1 | | 40 (| 0 | | | | | 1 🗆 Y | 8 2 No | 3 □ Proi | bably 4 ☐ Unknown | |
| | es tha igned be del | by F | Atheroscleratic | Coronal | MITE | ly Di | sease | | | | | ,,,,,, | | | |
| of Vital Records, | v requires been sign should be | Pa | M. alast M | Mitus | | , | | | | | 24a. Wes e | | 24b. W | ere eutopsy findings | |
| 00 | | Completed | Diabetes Me | MITW | | | | | | | perform | ned? | co | allable prior to impletion of cause death? | |
| Be | 0 - 0 | mc. | | | | | | | | | 4 🗆 V | 000 | | | |
| Ø | Iclan: The certificate rector, pag | | 25. Wes case referred to medical | | | | | | | | 1 □ Ye | . , , | 11 | ☐ Yes 2☐ No | |
| 5 | | o Be | examiner? | Hospitel: | | | | . Ot | hor | | Check only on | | | | |
| | Phys | - | 27. Menper of Death | | | ER/Outpatie | | A | 4 L N | ursing Hom | e 5 pt.Reside 3d. Describe ho | ence 6 Oth | | (1) | |
| Division | h. After fune | tion | 1 Naturel 5 ☐ Pending | 28e. Date of (Month) | Dey Year) | Injury | м | 8c. Inju Wo | ork?]Yes 2⊡ | | | and any cook | | | |
| S | Attending or death. ector: After by the fune | lica | 3 ☐ Suicide 6 ☐ Could not | be on Diese | f Injury - At h | ome farm si | | | | | of Location (St | reet and Num! | er or Rurs | al Route Number, | |
| 5 | or Attendia after death. Director: A I in by the fu | Certification: | 4 Homicide determine | building | , etc. (Specif | y) | ioot, idotory | , 011100 | | | City or Town | | | , | |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the | | 29a. Certifier 1 Cartifying | Physician: To the b | eel of my kno | wledge deel | th occurred t | at the ti | imo data a | nd place, an | d due to the or | auco/s) and my | 20000 00 0 | tatad | |
| | Fun Ptun Ptely | edical | | aminer: On the bas | is of examina | tion end/or in | vestigetion, | in my | opinion, de | ath occurred | at the time, de | ete and place, | and due to | the cause(s) | |
| | ithin on the | Me | 29b. Signature end title of certifier | ond mornic | district. | | 29c | Licen | se number | | 2 | 9d Date signe | d (Month | Dev Year) | |
| | F ≱ F ŏ | | 1 A+ 0 | Fau | NAM | | | Λ - | 327 | \cap | | 29d. Date signed (Month, Dey, Year) | | | |
| | | | Delay U. | any | MO | | | UD | 277 | -0 | | م ا ب | P | | |
| | 10 | | 30. Neme and address polyprison wh | o completed cause | of death (Item | 7 2 A | Print) | 0- | 1 | Rall | THA DIM | AAr | 21 | 211 | |
| | | | 31. Date filed (Month, Day, Year) | ///// | 2 | 1001 | alb | NC | Λ, | רוטעו | THUNDYE | עיעו | 41 | 611 | |
| | Sta Registi | | FEB 1 5 1996 | a divine | TAL COL | 4 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 03964

| | | | | , | C | ertifica | te of L | Death | | Reg. No. | 40660 | | | |
|----------|--|-------------------|---|--|----------------|-----------------------------|------------------------------|---------------------------------------|-------------------------------------|--------------------------------|---|--|--|--|
| | Dhoolei | | 1. Decedent's Nama (First, Middle, Las | st) | | | | | 2. Data of Da Month | aath | 3. Time of Death | | | |
| | Physici /Medic | | HENRY W. | BRIM | | | | | FEBRU | ARY 11,19 | 96 6:20 AM | | | |
| | Examir | | 4a. Facility Nama (If not Institution, give | street and number) | | | 41 | b. City, Town, or | | th 4c. County of | Death | | | |
| 1_ | | | UNIVERSITI 5. Social Security Number 8. \$ | / H | OSP | ITAL | - 111 | YBALTI | MORE | / | VA | | | |
| п | Funeral | 7 | 5. Social Security Number 8. \$ | ex. 7. Aga (In yrs | lest birthde | Months | or 1 Year Days | If Undar 24 Hrs Hours Min. | (Month D | rth ay, Year) | Birthpleca (Stata or Foraign Country) /ASH., DC | | | |
| ч | Director | | Usuel Residence of Dacadant | 7 | 2 | | 1 | | MAYSO | 1,1943 U | JASH., DC | | | |
| | nytand thow | | 10s. State 10b. County | 10c. C | ity, Town or | Location | | | | | 10d. Inside City Limits | | | |
| | Na Pal | ctor | MARYLAND | VA | | 1 | BAL | TIMO | RE C | CITY | 1 Yes 2 □ No | | | |
| | or 28 | Oire | 10e. Street and Number | | | 10f. Zi | ip Code | | | 10g. Citizen of Whe | at Country? | | | |
| | 23a | rai | 1925 HERBEI | RT STREE | | | | 2/2/ | 7 | 45 | A. | | | |
| | her death with the Marylar Items 23a or 28a-f show Inst. must be notified at | Funeral Directo | 11. Marital Status | 12. Wes Decedent Ever in Armed Forcas? | J,S. 1 | 3. Wes Dece If Yas, spe | edant of His | spenic Origin? (S n, Maxican, Puer | pecify Yas or No to Rican, atc.) | o- 14. Race - Black, | Amarican Indian, White, etc. | | | |
| 20 | n ah | by F | 1 ☐ Navar Married 2 🐧 Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 No If Yas, Giva Year or Detas: | | 1 🗆 Yas | 2 No | Specify: | | Specify: | BINAV | | | |
| 5-0020 | thursd pal E | | 15. Decedant's Ed | | 16a. De | cedent's Usi | ual Occupa | tlon | | 16b. Kind of Busin | 3LACK | | | |
| 215 | T UNIV | Completed | (Specify only highast grade Elementary/Secondary (0-12) | da complated) Collaga (1-4or 5+) | (Gi | iva kind of wa a. DO NOT | ork dona d usa retired) | uning most of wo | rking | | , | | | |
| 2 | d will piene pr the | E O | 11TH GRADE | Oonaga (1-401 34) | | TRUC | CK | DRIV | ER | DELIVER | SERVICE | | | |
| land | d of the state of | e B | 17. Father's Nama (First, Middle, Last) | | | | | | | , Maiden Sumame) | | | | |
| χ | ould Man mrks mrks | To | DANIEL | FRANKLIN | BR | 21M | | CLAR | A | (MN-C | INKNOWN) | | | |
| Mary | d 2 sh h and 7 ts re traum | | 19a. Informant's Name/Ralationship (7 | _ | 19b. Me | eiling Addras | s (Street a | nd Number or Ri | ural Routa Numb | ber, City or Town, St | ata, Zip Code) | | | |
| - | 1 and Healt em 2 Ather | | 20a. Mathod of Disposition | BRIM | Pleca of Dis | sposition (Ne | INGE | RI ST., | BALTI Data | MORE MY 20c. Location - Cli | Dy | | | |
| altimore | ages ant of triff le | | 1 A Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Ramovel from Stata | 7, | , , | | | | | | | | |
| = | nit. Pa artmon ortant: Injury | | 3/ Signature of Funaral Saryise Licen | | 1 | 22. Nama a | nd Addres | S of Fecility | | | IMORE, MD, | | | |
| ä | Dept permit perm | | (Augusta) | W/ | - | JOSEPH | н. в | ROWN JR | | AL HOME, P. | | | | |
| 100 | E 25330 | | 23a Part Timer the disaasa, or comp | plications that caused the def | n le not | L913 W antar tha mo | BAL | TIMORE : | ST., BAI | LTIMORE, Marrast, | Approximata | | | |
| - | Physician | | shoots or heart failura. List only o | me cause on aech lina. | 1 | | | | | | Onset end Death | | | |
| A | /Medical | | Immediata Causa (Final disaasa or condition | · HYPOVOL | EMIA | | | | | | | | | |
| п | Examiner | | resulting in daath) | | | sequenca of |): | | | | | | | |
| _ | po is | Examiner | LAPPER GASTROINTESTINAL HEMMORHAGE | | | | | | | | | | | |
| - | death certificate be executed attending physician and of for use as the buriel-trensit | xan | Sequantielly list conditions, if any, leading to immediata causa. Entar Undarlying Ceuse (Disease or Injury | Dua fo | or as a cons |): | | | | | | | | |
| 68760, | be e sician burie | | causa. Entar Undarlying Ceuse (Diseese or Injury that initiated avents | c | | | | | | | | | | |
| 687 | tificate ng phy as the | edic | rasulting In death) Last | Dua to (| or as a cons | sequence of) | : | | | | | | | |
| Box | attending | In/M | | d | | | | | | | | | | |
| | | sicia | Part II. Other significant conditions co | ontributing to death but not re | sulting in the | e undarlying | causa giva | n In Part I. | 23b. Did | tobacco use contri | bute to the cause of death? | | | |
| P.0 | \$ 60 m | Physician/Medical | | | | , | | | 1 | Y•• 2□ No 🌛 | Probably 4 Unknown | | | |
| | es tha igned be del | by | | | | | | | | | | | | |
| Records, | been should | Completed | | | | | | | 24a. Was perf | s an autopsy ormed? | 24b. Wera autopsy findings available prior to completion of cause | | | |
| Sec. | e law hes b | npie | | | | | | | | | of death? | | | |
| | E ag | | | | | | | | 10 | Yas 20 No | 1 Yas No | | | |
| of Vital | | Be c | 25. Was casa rafarrad to medical axaminar? | Hospital: | | | Othe | 28. Placa of De | | | | | | |
| | Phys ral di | : To | 1 ☐ Yas 2 ☐ No 27. Menner of Death | 1 III Inpatiant 2L | 28b. Time | tient 3 D | OA | 4 LI Nursing F | | how Injury occurred | | | | |
| 6 | F - N | tior | 1 Natural 5 Panding 2 Accident Invastigation | 28a. Data of Injury (Month, Day Year) | Injur | y M | 28c. Injury Work 1 ☐ Y | ? ′as 2 □ No | | | | | | |
| Division | Att octor by the | ifica | 3 Sulcide 6 Could not be determined | 28a. Placa of injury - At I | oma, farm, | street, facto | ry, offica | | 28f. Location | (Street and Number | or Rural Route Number, | | | |
| Ö | s afte | Certification: | ◆ □ Horricida | building, afc. (Spec | iry) | | | | City or To | iwn, Stata) | | | | |
| | To the Hospital or Attention 24 hours after designed to the Funeral Director completely filled In by the | edicai | 29a. Certifier Check only 2 Medical Exam | rsician: To the best of my kn | owledga, de | ath occurred | at the time | a, data and place | , and dua to the | causa(s) and mann | er as stated. | | | |
| | the H the F the F | Med | one) | and mannar stated. | ution onwor | | | | integrationa (integrational) | | | | | |
| | To To | - | 29b. Signeture end title of continu | 1 | | | oc. Licansa | | 7010 | 29d. Dete signed (1) | | | | |
| | | | 50 | p | | 19 | 417 | 643545 | 00/5 | | • | | | |
| Ĭ | D | | 30. Nama and addrass of person who o | omplated causa of death (Ita | m 23a) (Typ | ne, Print) | - 4 | D. " | 2120 | | | | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrer's Sign | | V | - | | | • | | | | |
| | Sla Pogistr | | FED 4 5 1000 1 | 1. As A. P . | - | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 6 0 3 9 6 5

| | | | | ٠ | | Certifica | ate of | Death | | Reg. No. | | | | | |
|---------------------|---|--------------------|---|---|---------------------------------------|--------------------------------------|---------------------------|---|---------------------------------------|---|----------------------------|--|-------------|--|--|
| | Physic | lan | 1. Decedent's Nema (First, Middle, L | est) | | | | | 2. Dete of De | eth | Voor | | el Desth | | |
| J | /Medi | | OSWALD | | | CHI | SHOL | | FEBRUAI | | 1996 | 03: | 13 M | | |
| Ú | Exami | ner | 4a. Fecility Nama (If not institution, gi | Cr. S. St. S. S. S. S. S. S. S. S. S. S. S. S. S. | _ | | | | Location of Deeth | 4c. Count | y of Death | | | | |
| L | | | GOOD SAMARITAD 5. Sociel Security Number 6. | | | eth double lift I lo | dar 1 Yaai | BALTIMO | | | N/1 | | - | | |
| | Funeral Director | | 214-68-2724 Usual Rasidence of Decedent | 120 M 2□ F | e (In yrs. lest bi | Yrs. Month | | | | y, Year) 5,1956 | 9. Birthp Coun I 1] | leca (State try) Lino: | or Foreign | | |
| | land wa | | 10e. Stete 10b. County | - | 10c. City, Tow | n or Location | | | | | 1 | 0d. inside | City Limits | | |
| | a-f sh | ctor | MD N/ | 'A | Ba1 | timor | е | | | | | OX Ye | s 2 No | | |
| | or 28 | Director | 10e. Street end Number | | | 10f. | Zip Code | | | 10g. Citizen of | Whet Coun | try? | | | |
| | 23a | | 6110 Chinquapi | n Parkwa | Y | | 212 | 39 | | | USA | | | | |
| 020 | n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show pared Exactine mart be notified at | by Funeral | 11. Marital Status 1 Nevar Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedant I Armed Forces? 1 Yes 2 An If Yes, Give Yaar or Detes: | Evar in U,S. | | cedant of pecify Cubs | Hispanic Origin? (ban, Mexican, Pue Specify: | Specify Yas or No rto Rican, atc.) | 14. Ra Ble Specia | ca - Amaric ick, Whita, | etc. | | | |
| 2-0 | 72 ho | eted | 15. Decedent's E (Specify only highest gi | ducation ade complated) | 16a | . Decedent's U | work done | during most of w | orkina | 18b. Kind of 8 | usiness/inc | lustry | | | |
| Maryland 21215-0020 | d within giene. r than " | Completed | Elementery/Secondery (0-12) | College (1-4or 5 | +) C | ocial | T use retire | ed) | ,,,,,,,, | Но | using | 3 | | | |
| | | | 12th 17. Fether's Neme (First, Middle, Las | 4 | 3 | OCIAI | WOI | | eno (Eiset Atiololis | Maidan Cuma | 1 | | | | |
| | 2 2 2 2 | Be | Oswald E. Chi | | | | | | G. Jon | | | | | | |
| | 2 should and Men is marke aumatic | 2 | 19e. Informent's Name/Rejetionship | | 191 | Mailing Addr | ess (Stree | at and Number or F | | | | Code) | | | |
| | aith ar 27 Is rr trau | | Gordine Blount | | | | | y Road, | | | | | | | |
| re, | - 9 5 5 | | 20e. Method of Disposition | | 20b. Pieca o | f Disposition (f | Vame of | | Dete | 20c. Location | | | | | |
| altimore, | Pages nent of nrt: If it | | 1 ☐ Burlel 2 ②Cramation 3 [4 ☐ Donation 5 ☐ Other (Speci | | | Crema | , | , | 2/14 | Baltin | nore | Mary | /land | | |
| Balti | permit. Pag Department Important: I eny injury o | | 21. Signatura of Funarei Servica Lica | ns#® | 10 H | 22. Nama | and Addr | ass of Facility DYETT | & SON | FUNERA | AL HO | | INC. | | |
| | _ | | 23a Party Exter the disease a con | colinations that caused | An death Do | 4600 |) LI | BERTY H | EIGHTS | AVENU | E 21 | 207 | | | |
| | Physician /Medical Examiner | ler | 23a Enter the disease complications that cause die death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Due to (or as e consequence of): | | | | | | | | | | | | |
| Box 68760, | h certificate be executed anding physician and use as the burial-transit | n/Medical Examiner | Sequentially list conditions, if eny, leeding to immadiate cause. Enter Undarlying Cause (Diseese or injury that initieted evants resulting in death) Last | c | Due to (or es e | | | | | | | | | | |
| | death ed for u | sicie | Pert II. Other significant conditions | contributing to death bu | it not resulting in | n the underlying | g cause gi | iven in Pert i. | 23b. Did 1 | obacco use co | ontribute to | the cause | of death? | | |
| s, P.O. | requires that the death ce | by Physician/ | | | | | | | 10 | Yes 2□ No | 3 Prot | ably 4 | Unknown | | |
| Records, | requires seen sign should be | ompleted | | | | | | | 24a. Was perlo | an eutopsy med? | ave | re eutopsy sileble prior apletion of | rto | | |
| Rec | 0 2 3 | E G | | | | | | | 1/ | | of c | death? | | | |
| ā | | ပိ | of Manager and American | | | | | | 1 | res 2□No | 1 | Yes 2 | □ No | | |
| Vita | 1 30 | 100 | 25. Wes case reterred to medical exeminer? XXXYes 2□ No | Hospitei: | · · · · · · · · · · · · · · · · · · · | dn. a42-a4 BD | DOA Ot | hon | ath (Check only o | | , | | | | |
| ion of | Attending Physic death. actor: After the by the funeral d | ation: T | 27. Megnar of Death Natural 5 Pending invastigation | 28e. Dete of injur (Month, Dey | | troatient 3 Time of injury | 28c. Inju | 4 LI Nursing | Home 5 Resid | | | ") | | | |
| Division | Patro | Certification | 3 Suicide 6 Could not be determined | 28e. Pieca of Inju building, etc | ry - At home, te . (Specify) | orm, street, fect | tory, office | | | ion (Street and Number or Rural Route Number, r Town, Stata) | | | | | |
| | To the Hospital within 24 hours or the Funeral completely filled | edicai | 29a. Certifier (Check only one) | ysician: To the best on miner: On the basis of end manner stell | examinetion en | e, deeth occurre d/or Investigeti | ed et the ti on, in my | ime, dete end plec oplnion, death occ | a, end due to the curred et the time, | cause(s) and m date end place, | enner es st end dua to | ated. the cause | (s) | | |
| | Within To the comple | Me | 29b. Signature end titla of certifier | | 1 | 2 | 29c. Licen | sa number | | 29d. Dete signe | d (Month, I | Day, Year) | | | |
| 1 | a | | Theodor | M. Ku | & u | v | o.c | .M.E. | F | EBRUA | RY 13 | 199 | 96 | | |
| | | | 30. Neme and address of person who | 4 - | 100 | | | | | | | | 1201 | | |
| | | | 31. Deta tiled (Month, Dey, Year) | | 11 | 1 Peni | n_St | reet, B | altimor | re, Ma | rylai | 1a 2. | 1201 | | |
| | Sta Registr | | 1 5 1996 S | he diversor | andell | | | | | | | | | | |



Item1 2-15-96 FilmG732 W.H.Per F/H Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 3 9 6 6 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth ALBERT CONNOR Earl Conner Sr. **Physician** Month 13 1155 AM FEBRURY 1996 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CENTER BALTIMORE HOSPITAL HARBOR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 8 Yrs. Montha Deya Hours Min. (Month, Day, Year) May 9, 1917 5. Social Security Number 6 Say Birthplace (State or Foreign Country) **Funeral** 180 M 2□ F 213-07-2600 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore. Dundalk 1 Yes 2 No Director 7 is marked other than "natural", or items 23a or 28a-4 traumetic event, the Medical Examinat must be notified 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 1959 Guuwau 21222 United States Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wea Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Datea: WWI 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 Ho Specify: þ 3 Widowed 4 □ Divorced Specify: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pem)t. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) 7 Years Tin Mill Steel Worker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Samuel Conner Lina Not Known 19a. Informant's Name/Reletionship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora Stevens 1959 Guyway Dundalk. Maryland 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 2/15/1996 Baltimore. Maryland 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part Enter the disease, or complications that cause it has death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Due to (or es e consequence of): CONGESTIVE HEART FAILURE physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, CORONARY ARTERY DISEASE Physician/Medical Due to (or as a consequence of): DIABETES MELLITUS 15 years Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 28. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie and manner steted.

20 Anadical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) AS 2441614-66 FEBRURY 13,1996 MEDICAL DOCTOR 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

SAJA BOR HOSPITAL CENTER 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 1 5 1996

Registrar DHMH 16 Rev 6/95

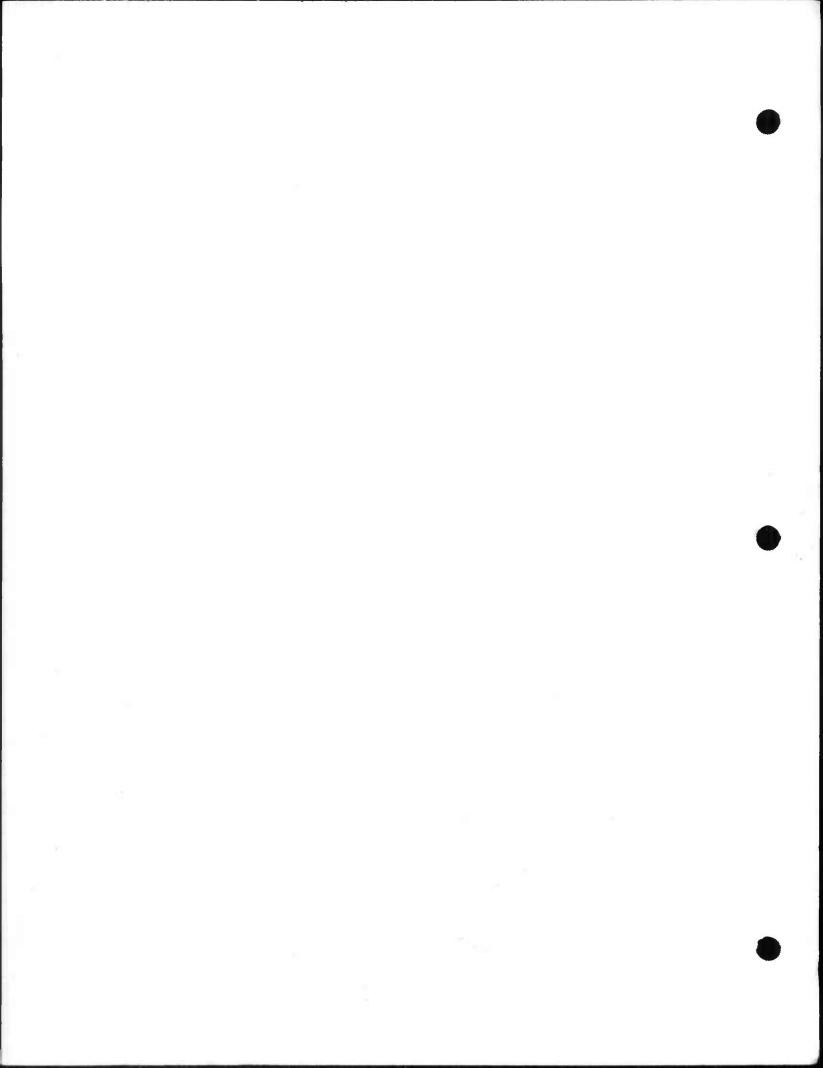
) physician. e burial-transit permit. Pages 1, 2, 3 should BALLIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| a Carra Idelica ad Cr | TO BE COMPLETED BY PHYSICIAN: MEDICAL CEDTIFICATION |
|--|---|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| e funeral director, page 5 should be detached for use as the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the |
| Page 6 may be retained by the hospital or attending | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours and each of a fine some that hospital or attending |
| | |

| STATE OF | MARYLAND / | DEPARTMENT | OF HEALTH | AND I | MENTAL | HYGIENE |
|----------|------------|------------|-----------|-------|--------|---------|
| | CE | ERTIFICATE | OF DEAT | 'H | | BEG NO |

| | 1 - FOR STATE OF MARYLAND C | DEPARTMENT OF | | RENTAL HYGIEN | E | | | | | | | | |
|---------------|--|--|---|---|--------------------|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | | | |
| | Lala C. | Clarke | - 1 | Feb. 13 | | 11:15 am | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. la | ist birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | S. BIRT | THPLACE (State or Foreign | | | | | | | |
| | 577-24-8919 '□™²\\F 92 | YRS. MONTHS DAYS | HOURS MIN. | (Month, Day, Year) J111 V 19 1 | 1903 | Country) | | | | | | | |
| | Se. FACILITY NAME (If not institution, give atreet and number) | 9b. CITY, TOWN | OR LOCATION OF DEA | | 9c. COUNTY OF | Maryland | | | | | | | |
| S S | St. Martin's Home (LSOP) | Cat | onsville | Baltimore | | | | | | | | | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | Dareimore | | | | | | | |
| DIRECTOR | Florida Broward | 10c. CITY, TOWN OR LOCA | ™ Hallanda | .1 - | | 10d. INSIDE CITY LIMITS? | | | | | | | |
| | 10e STREET AND NUMBER | | | 116 | | 1 TYES 2 NO | | | | | | | |
| FUNERAL | 160 North East 8th Avenue | 1 1 | r. ZIP CODE 330(| 0.0 | | WHAT COUNTRY? | | | | | | | |
| | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A | - | | | | SA | | | | | | | |
| BY FL | t Never Merried 2 Merried TORCES 1 YES 2 X Widowed 4 Divorced TORCES 1 YES 2 X IF YES, GIVE WAR OR DATES | NO If yes, s | pecify Cuben, Maxican, 3 2 Tr NO Specify: | C ORIGIN? (Specify Yea , Puerto Rican, etc.) | Bla | CE American Indian, ck, Whita, atc. | | | | | | | |
| | 15. DECEDENT'S EDUCATION 16a. O. | ECEDENT'S USUAL OCCUPATI | ON | THE VIND OF BUILD | 1 | White | | | | | | | |
| | (Specify only highest grade completed) ((| Give kind of work done during me. Do NOT use retired.) | ost of working | 16b. KIND OF BUS | SINESS/INDUSTRY | | | | | | | | |
| COMPLET | Conege (1-t of 5+) | omemaker | | Own Ho | me | | | | | | | | |
| S | 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAM | E (First, Middle, Maiden | | | | | | | | | |
| | Thomas Fenny Buckler | | | e Lyon | ourname) | | | | | | | | |
| BE | | bb. MAILING ADDRESS (Street | | | 1 State Zin Code) | | | | | | | | |
| 임 | Francis L. Buckler, Jr. 2 | 304 Apache | Street | Hyattsv | ville, | MD 20783 | | | | | | | |
| | 1 LX Burlet 2 L Cremation 3 L Ramoval from State cemetery, co | AND DATE OF DISPOSITION (Nametory or other place) | | | CATION — City or 1 | | | | | | | | |
| | 4 Donetion 5 Other (Specify) South | rn Memorial | | | th Miami | , FL | | | | | | | |
| - 2 | 21. SIGNAPORE OF FUNERAL SERVICE LICENSEE DAWN F. McDonald 22. NAME AND ADDRESS OF FACILITY MacNabb Funeral Home, P.A. | | | | | | | | | | | | |
| | - www. M. M. D. may | | | | | MD 21228 | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Finsi | . | | | | Onset and Death | | | | | | | |
| | disease or condition | 212 | | | | 5 days | | | | | | | |
| | OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 5 | Sequentially list conditions, | | | | | | | | | | | | |
| | Sequentially list conditions, If any, leading to immediata cause, Enter UNDERLYING | | | | | | | | | | | | |
| 5 | CAUSE (Disease or injury C. | OUENCE OF: | | | | | | | | | | | |
| CEHIIFICATION | that initiated events resulting in death) LAST | | | | | | | | | | | | |
| | 0. | | | | | | | | | | | | |
| Ž I | PART II. Other significant conditions contributing to death but not | A - | | PERFOR | MEO? | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | | | | |
| MEDIC | Diabetes mellitus, cancer | of Colon | , hypothi | projett VES 2 | X NO | COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| | | | invent str | bkes. | | 1 - YES 2 - NO | | | | | | | |
| TSICIAN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA | | UNCERTAIN | | | | | | | | | | |
| 2 | EXAMINER? HOSPITAL: | OTHER: | | | | | | | | | | | |
| 2 | 1 VES 2 NO 1 Inpatient 2 ER/Outpetlent : | DOA 4X Nursing Hon | ne 5 🗆 Rasidence 8 | ☐ Other (Specify) | | | | | | | | | |
| | 27. MANNER OF DEATH 1 That Natural 5 Pending 28a. DATE OF INJURY (Month, Day, Year) | INJURY WO | DRK? | 28d. DESCRIBE HOW IN | IJURY OCCURED | | | | | | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At he | | YES 2 NO | nes I continue (n | | | | | | | | | |
| 3 | 6 Could not be building, atc. (Specify) | one, term, screet, factory, offic | • | 28f. LOCATION (Street a City or Town, State) | na Number or Hurel | Houle Number, | | | | | | | |
| | 29e. CERTIFIER | | | | | | | | | | | | |
| E I | (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, do one) 2 MEDICAL EXAMINER: On the basis of examination and/or | | | | | A TABLE BILLIANS | | | | | | | |
| 3 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | | | |
| | Kanal & Days | | D 1836 | | | D (Month, Day, Year) | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE | M 27) (Time Print) | 01031 | 04 | reb. | 13, 1996 | | | | | | | |
| | KOMALK, DANG MD., 3455, | Wilkens A | R. Ba | Ito, Mo | 12122 | a | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | ALTIMON I) | 7, 140 | 10111110 | 1 4 4 | , | | | | | | | |
| | FFR 1 5 1996 Solve Marine | | | | | | | | | | | | |
| | TO THE TOTAL PROPERTY OF THE PA | | | | | DHMH-16 Rev 1/89 | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once. BACTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | REGISTRAN | | | | CERTI | TCAL | E Ur | DEA | IH | | REG. NO | | | | |
|---------------|---|-----------------------------------|----------------------------|----------------|-------------------|---------------|-------------|--------------------|------------|---------------------|--------------------------------|---------------|----------------|---|------------------|
| | 1. DECEDENT'S NAME (First | | | | | | | | | 2. DATE | OF OEATH | AY | YEAR | 3. TIME | OF DEATH |
| | | Elou | ise (| Copel | and | | | | | Feb | | | 96 | 1:1 | 15 n M |
| | 4. SOCIAL SECURITY NUM | | 5. SEX | 6. AGE (in y | rs. lest birthday | IF UNDE | R 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE | OF BIRTH | , | | | State or Foreign |
| | 156-07-7 | 321 | 1 M 2 X F | 79 | YRS. | MONTHS | DAYS | HOURS | MIN. | | Day, Year) | 016 | Countr | y) | |
| | 9e. FACILITY NAME (If not in | stitution, give str | met and number) | | | 05 017 | Y TOWAL | OR LOCAT | 1011 05 01 | Aug. | 21, 1 | | North Carolina | | |
| œ | 2433 Ann | | 90. 01 | | ltim | | | | | /A | EATH | | | | |
| DIRECTOR | RESIDENCE OF DEC | | - GIOIMOIC | | | | 1V / A | | | | | | | | |
| <u> </u> | toa. STATE | 10c, C | TY, TOWN | OR LOCA | TION | | | | | | 104 IM | BIOE CITY | | | |
| 뜻 | Maryland | N/ | A | | | | | Balt | imor | re | | | - 1 | LIN | AITS? |
| | 10s. STREET AND NUMBER | | | | | | | | | | | | 21 | ES 2 NO | |
| ¥ | 2433 Anno | | 101. ZIP CODE 2123 | | | | 30 | | 10g. CITI | | | UNTRY? | | | |
| BY FUNERAL | | | | | | | | | US | USA | | | | | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Merried 12. WAS DECEOENT EVER IN U.S. A FORCES? 1 YES 2 | | | | | 13. | WAS DE | CENCENT Cube | OF HISPAN | NIC ORIGIN | (Specify Yes | or No- | 14. RACE | IACE — American Indian, Ilack, White, etc. | |
| ≿ | 3 Widowed 4 Divo | | IF YES, GIVE W | | | | 1 TYES | 8 2 NO | Specify | y: | roari, etc.) | ł | Speci | ffy: | |
| | Black | | | | | | | | | | | | ck | | |
| 回 | 15. DEC (Specify onl | EOENT'S EOUC y highest grade o | ATION completed) | 16 | Give kind of | work done | during m | ON ost of worki | ina | 16b. | KINO OF BU | SINESS/INC | USTRY | | |
| Ш | Elementary/Secondary (0 |)-12) | College (1-4 or 5 | | life. Do NOT | use retired.) | | | | | | | | | |
| ₽ | 11 | | | | Homem | akeı | <u> </u> | | | 01 | vn Ho | me | | | |
| COMPLETED | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, M | iddle, Maiden | Sumeme) | | | |
| BE (| Alan | Hack | ney | | | | | | Cres | sie : | Nunn | | | | |
| 10 | 19e. INFORMANT'S NAME (7 | ype/Print) | | | 19b. MAILIN | G ADDRES | S (Street | | | | er, City or Tow | n, State, Zip | Codel | - | |
| ¥ | Constance | Rich | burg | | | | | | | | timor | | | 123 | 10 |
| ľ | 200. METHOD OF DISPOSIT | ION | | 20b. PL | ACE AND DATE | | | | | CATE | 20c. LO | CATION - | City or To | wo State | |
| | 1 Donation 5 Other | n 3 🗆 Ramo (Specify) | val from State | comoto | ni neamentoni ci | abbas alasal | | | 02/ | | | | | | |
| | | | ENSEE DOLL | E Mo | o Cren | 22 | NAME A | NO ADDRE | SS OF FA | 10/90 | р | 1111 | nore | , IV | ID |
| | PL SUCHATORIE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald Cremation Society of Maryland, Inc. | | | | | | | | | | | | | | |
| | NW | 10. | MACH | Mar | 1 | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final) Interval Between | | | | | | | | | | | | | | |
| ĺ | | | | | | | | | | | | | | | |
| | disease or condition resulting in death) s. Metastatic gastric carcinoma 6 minths OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| - | | | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| A | couse. Enter UNDERLYING | | | | | | | | | | | | | | |
| Ē. | CAUSE (Disease or Inju that initiated events | η) | OUE TO | (OR AS A CO | NSEOUENCE (| UENCE OF); | | | | | | | | | |
| E | resulting in death) LAS | т 📗 " | | | | | | | | | | | | | |
| 빙 | d | | | | | | | | | | | | | | |
| EDICAL | PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMEC? AND ADJA PART II. 24a. WAS AN AUTOPSY PERFORMEC? | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | _ | 1 YES 2 | | | COMPLE | TION OF CAUSE |
| | | | | | | | | | | _ | 1 123 2 | X | | OF DEAT | |
| ≥ | DID TOBACCO U | SE CONTR | IBLITE TO CA | LISE OF I | DEATH V | EC | NO E | LINIC | ERTAIN | | | | | 1 U YE | S 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO | | DOIL TO CA | | PLACE OF OE | | | 1 0140 | EKIAII | 4 🗆 [| | | | | |
| 8 | EXAMINER? | | HOSPITAL: | | | OTHE | R: | | | | | | | | |
| ¥ | 27. MANNER OF OEATH | | t Inpatient 2 | | | | | | esidence | 8 Other | | | | _ | 1 |
| | | Pending | (Month, De | | 28b. Til | JURY | | PRK? | | 28d. OE\$6 | RIBE HOW II | NJURY OCC | UREO | | |
| B I | | rivestigation | | | | ** | | YES 2 | NO | | | | | | |
| ₽ | | Could not be determined | 25e. PLACE Of building, | atc. (Specify) | At home, ferm, | strest, feci | tory, offic | • | | 28f. LOCA City o | TION (Street e Town, State) | nd Number | or Rural A | bute Num | ber, |
| COMPLETED | - C Tremitore | 24.07.11111100 | | | | | | | | | | | | | |
| 7 | 29e. CERTIFIER (Check only | IFYING PHYSIC | IAN: To the best of | my knowledg | e, death occur | ed at the t | ime, date | end place | , end due | to the caus | e(s) end man | ner ee state | od, | | |
| 8 | | | On the beele of ex | | | | | | | | | | | end mar | nner as stated. |
| | 29b. SIGNATURE AND TITLE | | , | | | | | | | | | | | | |
| BE | () M | 1).1 | | | | | | I) 1 | ENSE NUM | Da | | 29d. DATE | | | |
| 2 | 30. NAME AND ADDRESS OF | 7 | COMPLETED CALL | | 11984 | 0 | | VO | (d) | 07 | | Fe | b. | 14, | 1996 |
| | AND ADDRESS OF | / // a | / CAUS | SE OF GEATH | 17 | 1 | 1/ | 17 | , , | 1 | | | | | |
| | 1/Von a | · 35 er | Kman | mo | | 505 | No. | colta | / (| PAT | Cr_ | | | | |
| | 31. DATE FILEO (Month, Day, | | 32. REGISTRA | R'S SIGNATU | RE | | (| 0 | | | | | | | |
| - 10 | FFR1 510 | 96 | U d'avolue | mark | K | | | | | | | | | | |
| | | | | | | | - | | | | | | | | |

| 1 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 1 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 fled within 72 hours after death with the State Degr. of Health and Mental Hygiene prior to burial, cremation, or removal. APORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|
|---|

| | 15em1 2-13-90 F11mG/32 W.E | 141 701 1711 | | | | | | | | | | |
|------------------|---|---|-------------------------------|---|------------------------|--|--|--|--|--|--|--|
| | 1 - FOR STATE OF MARYLAND / DEPA REGISTRAR CERTIFICATION CONTRACTOR CERTIFICATION CONTRACTOR CONTRA | RTMENT OF I | | MENTAL HYGIENE REG. NO. | | | | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) Miriam Peggy Chee | eks | | 2. DATE OF DEATH DAY FOLKER 12. | 1996 | 3. TIME OF DEATH 727 PM | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 212-30-6018 5. SEX 6. AGE (in yrs. last birthday for the second | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF POTTN (Month, Dly Yber) May 26, 1933 | Mai | cyland | | | | | | |
| TOR | Be. FACILITY NAME (If not institution, give street and number) Mercy Hospital RESIDENCE OF DECEDENT | | on Location of oi | | COUNTY OF | DEATN V/A | | | | | | |
| FUNERAL DIRECTOR | 10e. STATE 10b. COUNTY 10c. C | Baltimore | | 15 | | 10d, INSIDE CITY LIMITS? 1X YES 2 NO | | | | | | |
| VERAL | 2406 Winchester St., Apt. I | 10 | 21216 | 10-9 | J | WNAT COUNTRY? JSA | | | | | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 M Diverced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 M NO IF YES, OIVE WAR OR DATES | If yes, s | | NIC ORIGIN? (Specify Yea or No In, Puerto Rican, atc.) | 14. RAC Blac Spe | E — American Indian, ck, White, etc. Black | | | | | | |
| COMPLETED | (Specify only highest grade completed) (Give kind (ifte. Do NOT iffe. | rs usual occupation work done during many retired.) | ost of working | Baltimore Public Sci | | System | | | | | | |
| BE COM | 17. FATNER'S NAME (First, Middle, Last) Robert Brown | | 18. MOTNER'S NA | ME (First, Middle, Meiden Sume nzella Cathe | rine J | Jackson | | | | | | |
| TO . | Stephanie Rachel Blackwell 220 | Bolivar A | Ave. Balt | Anoute Number, City or Town, State imore, MD 21 | 225 | 1 | | | | | | |
| | 1 Burlel 2 Tremetion 3 Removal from State 4 Donation 8 Other (Specify) Metro Cr | ematory, | Inc. 02/ | 14/96 Balti | | | | | | | | |
| | 21. SIONATORE OF FUNERAL SERVICE LICENSEE Dawn F. McDonal | Crema | | iety of Mary Rd. Baltimo | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (9A AS A SONSEQUENCE OF): A THE MENGE TH | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE of the consequence of the consequen | | Faile | ure | | | | | | | | |
| EDICAL | PART II. Other algorificant conditions contributing to death but not resulting Hepatits C In feeth | in the underlyle | ng cauae given in | Part I. 24a. WAS AN AUTO PERFORMED 1 YES 2 | | MAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? | | | | | | |
| AN: M | | YES NO | UNCERTAI | N 🗆 | | / | | | | | | |
| PHYSICIAN: | EXAMINER? 1 VES 2 VNO HOSPITAL: 1 Vinpatient 2 ER/Outpatient 3 DO/ | OTHER: | me 5 🗆 Realdenca | 6 Other (Specify) | UI-II | | | | | | | |
| | Natural 5 Pending (Month, Day, Year) | INJURY W | IJURY AT PORK? YES 2 NO | 28d. OEŞCRIBE NOW INJUR | Y OCCURED | | | | | | | |
| ETED BY | 2 Accident investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — A1 home, fan building, etc. (Specify) | m, street, fectory, off | ice | 281. LOCATION (Street end N City or Town, State) | umber or Rura | l Route Number, | | | | | | |
| COMPLE | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occ 2 MEDICAL EXAMINER: On the best of exemination end/or investig | | | | | h(s) end manner ee stated. | | | | | | |
| TO BE | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (7 | Sona Brints | PO G | 7/33 P | Fe. | ED (Month, Day, Year) 6 12, 1996 | | | | | | |
| | DAVID BADAWE, MD | | HOSPITA | AL BALTI | MOR | EMP | | | | | | |
| | 31. DATE FILED (Month, Day, Year) FER 1 5 1996 This divides hardely | | | | | | | | | | | |

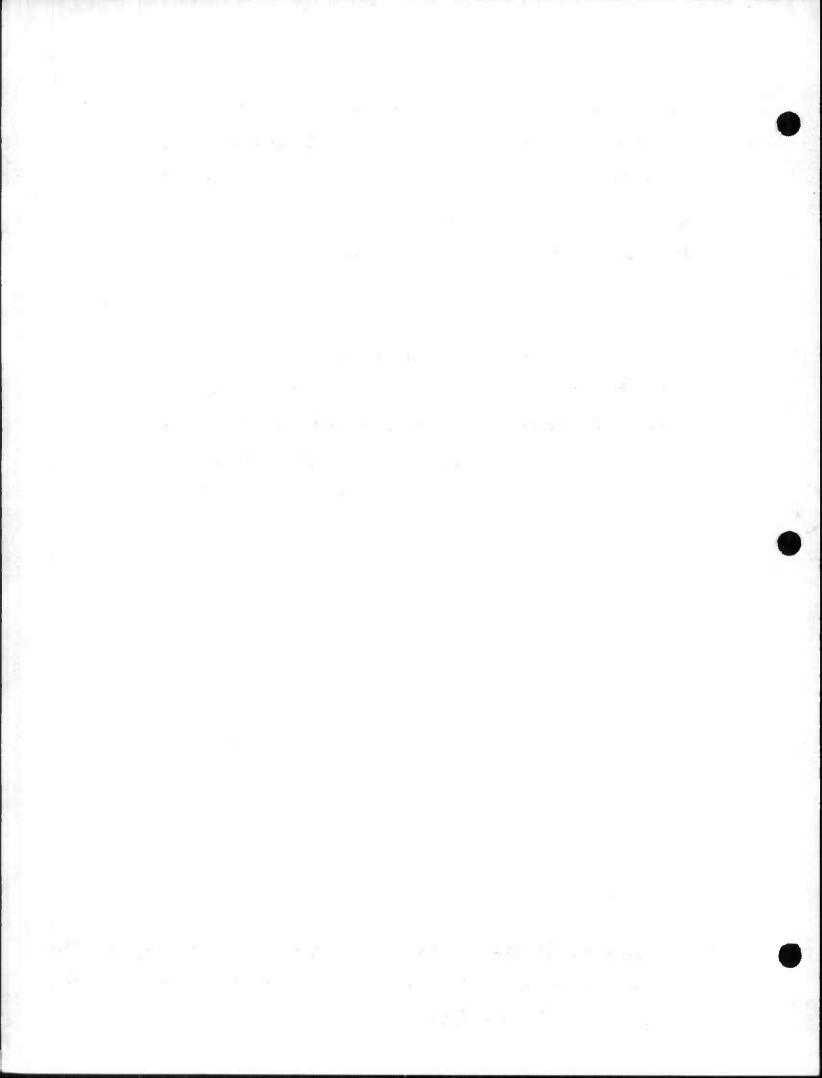
William Mary Town

State of Maryland / Department of Health and Mental Hygiene 9 5

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death Month Day 13, 1996 **Physician** CHARLES CATHELL 12:30 AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1**∑** M 2□ F 39 Yrs. Jan. 9, 1957 Director 216-72-6047 Maryland Usuai Residenca of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23s or 28a-f show treumstic event, tre Medical Examiner must be notified at 1 Yas 2 No Director MD. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with a Hyglene.
Other than "natural", or frems 23a or 2 307 Sedgefield Court 21015 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) years Risk Manager Contractor permit. Peges 1 and 2 should be file Department of Health, and Mental Hy Important: if flem 27 is marked other any july or other treumatic event. pots. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles H. Cathell Barbara Ann DeGreif 2 19a. informant'a Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne R. Cathell (Wife) 307 Sedgefield Court, Bel Air, Md. 21015 20a. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 2/16/96 Bel Air, Maryland 21. Signature of Funaral Service Licansee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Will 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or raspiratory arraat, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical immediate Cause (Final disaasa or condition resulting in death) malignant brain Examiner Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): rasulting in death) Last signed by the a Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peed completion of cause of death? hes certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) ٩ 1 Yes 2 No After this 27. Menner of Death uneral 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending in 24 hours after deau...
the Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13, 1996 merce D. Ohme M.D. 19481 30. Name and addrass of person who completed cause of death (item 23e) (Type, Print) 600 N. Welfe Street Bultimore MD Laurence O Phines Johns Hopkins Hospital 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 5 1996 Davidson Redall Registrar

O



| | | 1 Decedents Nove # | Claud Add to a | net) | | | Jen | ticate | or | Death | | | Reg. No. | 1 | | |
|---|---|--|-------------------------------|---|--|-------------------|---|--------------------------------------|---|---|------------------------|--------------------------------|--------------------------------|---------------------------------------|-------------------------------|--|
| Physici. | | 1. Decedant's Nama (F | rirst, Middia, Li | 181) | | | | CON | JLE | EY | | 2. Data of D Month FEBRU | Day | Yaar | Tima of Death 4:11 Al | |
| /Medic Examin | | 4a. Facility Nama (If no | ot institution, gh | a street and nu | ımber) | | | | | | wn, or Lo | ocation of Dea | | y of Death | 1 - 1 1 111 | |
| | | 1702 GWY | NN FA | LLS PA | RKWA | Y | | | | BALT | IMO | RE | | na | | |
| Funeral Director | | 5. Social Security Num 214-22-2 | | Sax NOM 2□F | 7. Aga (Ir | 69 Y | July / | If Under 1 Months | Yaar Days | | 24 Hrs. Min. | 8. Data of Bi (Month, D | irth lay, Year) - 2.6 | | (Stata or Foreign | |
| D. | | Usual Rasidance of Da | | | | | | | | | | | | | | |
| larylan show | | 101 | Ob. County | _ | 10 | c. City, Town | | | | | | 10d. Insida City Li | | | | |
| Ne M | Director | MD | n/ | d | | | alt | imoı | | | | | | | | |
| Vith to | | 10e. Straat and Numba | | | | | | 10f. Zlp C | | | | | | What Country? | | |
| s 23 | rai | 2570 W. | Lara | | | | | | 21 | | | | US | | | |
| laryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental hygiene. Is marked other than "naturel", or items 23a or 23s-1 show armatic event, the Medical Example must be notified at | by Funeral | 11. Marital Status 1 □ Navar Marriad 3 □ Widowed 4 □ | | 12. Was Dec Armed For Vas If Yas, G | edant Evar orcas? 2 □ No iva oatas: WW | | | is Deceda ′as, specif ີ Yas 21 | | Hispanic Orl an, Maxicar Specify: | igin? (Sp 1, Puarto | ecify Yas or N Rican, atc.) | o- 14. Ra Bla Speci | ce - Amarican fin ack, White, etc. | dian, | |
| P Hou | | | . Decedant's E | | 20(03. * * * * * | | 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/in | | | | | | | | , | |
| A I A I D-00 A O within 72 hours aff giene. or than *natural*, or the Medical Example. | Completed | (Specify Care Spec | only highast gr | ada complated) | (1-4or 5+) | | | of work NOT usa | | during mos | t of work | ing | | | | |
| of 2 should be filed to and Mental Hygin and Mental Hygin 7 is marked other traumatic event, in | | 17. Father's Neme (Fire | st, Middla, Lasi |) | | | пас | orei | omino S | ougar | | | | | | |
| should be filed nd Mental Hygi marked other imatic event, | o Be | Leon Co | nlev | | | | | | | | Mad | eline | HAwkir | n e | | |
| d 2 should th and Men 7 is marks traumatic | - | 19e. Informant's Name | /Reletionship | Type, Print) | | 19b. | Melilng | Address (| Street | | | | | n, Stata, Zip Code | 9) | |
| 75.5 | | Guy Con | lev | | | 3 | 1 B | ond | Δτ | re. R | eis | toreta | own MI | 21136 | | |
| ges 1 and tof Health If Item 27 or other tr | Ì | 20e. Method of Disposi | ition | | 2 | 20b. Placa of C | Disposit | ion (Name | of | C . J.S | CIS | Data | | - City or Town, S | | |
| Department of Healt Important: If Item 27 any injury or other | | #Deurial 2 □ C 4 □ Donation 5 □ | Other (Special | fy) | Stata | | n P | ark | | | | 2-19 | Balto | o., MD | | |
| Depart Support | 4 Donation 5 Other (Specify) Loudon Park 2-19 Balto. 22 Name and Addrass of Facility James A. Morton & Sons Funer 1701 Laurens St. BAlto., MD | | | | | | | | | | | | | eral HC 2121 | me 7 | |
| | | 23a Party Entar the control or heart fa | disaasa, or com | plications that | causad the | death. Do no | | | | | | | | | roximata rval Between | |
| Physician | ı | 0 | , | | | | | | | | | | | Ons | et end Death | |
| /Medical Examiner | | Immediata Causa (Final diseasa or condition resulting in death) a. Aherosulorohi (ardidivascular direase | | | | | | | | | | | | | | |
| | | resulting in daath) | | a | | | | | | | | | | | | |
| sit ad | line | Dua to (or es e consequance of): | | | | | | | | | | | | | | |
| e be executed rsician end e bune-trensit | Sequentially list conditions, if any, leading to Immediate course. Early, leading to Immediate course. Early, leading to Immediate course. Early, leading to Immediate. | | | | | | | | | | | | | | | |
| o ex | cal Ex | | | | | | | | | | | | | | | |
| sate t | | that initiated avants rasulting in death) Last | nsaqua | nce of): | | | | | | | | | | | | |
| The law requires that the death certificate ate hes been signed by the attending phys page 2 should be detached for use es the | Physician/Medi | nooning in Godiny Leat | | | | | | | | | | | | | | |
| thencor us | an | | | <u> </u> | | | | | | | | | | | | |
| the a | ysic | Part II. Other significan | nt conditions | contributing to d | leath but no | ot rasulting in t | ha und | arlying cau | isa gh | van in Part I | l, | 23b. Dfd | tobacco use c | ontribute to the | cause of death? | |
| res that the de | | | | | | | | | | | | 1 🗆 | Yes 2 No | 3 Probably | 4 ∰Unknown | |
| signe bed | þ | | | | | | | | | | | - | | T | | |
| v require been si should | Completed | | | | | | | | | | | | s an autopsy ormad? | avallable | utopsy findings a prior to | |
| hes b | D D | | | | | | | | | | | | | of daath | tion of causa 1? | |
| The la | S S | | | | | | | | | | | 1 🗆 | Yaa 200 No | 1 □ Yes | 2 □ No | |
| ysician: The is certificate director, pag | Be | 25. Wes casa rafarrad axaminar? | to medical | | | | | | | 26. Piece | of Daat | h (Check only | ona) | | | |
| Physic this co | 2 | 1 Nas 2□ No | | | Inpatiant | 2 ER/Outp | atient | 3□ DOA | Oth | har: 4 Nu | ursing Ho | ma 5 Ras | idence 6 🗆 Of | har (Specify) | | |
| ng Her | on: | 27. Mannar of Death 1 ☑Natural 5 | Pending | 28a. Dete (Mor | of Injury oth, Day Ye | ar) 28b. Tir | na of ury | 286 | . Inju | ry at rk? | | 28d. Describe | how injury occu | rred | | |
| death. ctor: A y the fu | cat | 2 Accident | invastigatio | n | | | | М | 10 | Yas 2 | No | | | | | |
| To the Hospital or Attant within 24 hours after deal To the Funeral Director: completely filled in by the | Certification: | 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) | | | | | | | | | | | (Straat and Num own, Stata) | ber or Rurai Rou | ita Number, | |
| Hospita 24 hours Funera tely fille | edical | (Check only 2 X | Certifying Ph Medical Exar | niner: On the b | asis of exa | mination end/ | daath o | ccurred at | d at tha tima, deta and placa, and dua to tha causa(s) and mannar as stated. n, in my opinion, deeth occurred et the time, date end placa, and dua to tha cause(s) | | | | | | | |
| the hin 2 the mplet | Med | onej | | and man | ner stated. | | | | | | | | | | | |
| 0 = 0 5 | - | 29b. Signatura and title | or certmar | 12/1/ | / | | | 29C. | Licans | sa number | | | ∠90. Data sign | ed (Month, Day, | raar) | |
| N A M | | | C | O.C.M.E. FEBRUARY 14 19 | | | | | | | | | | | | |

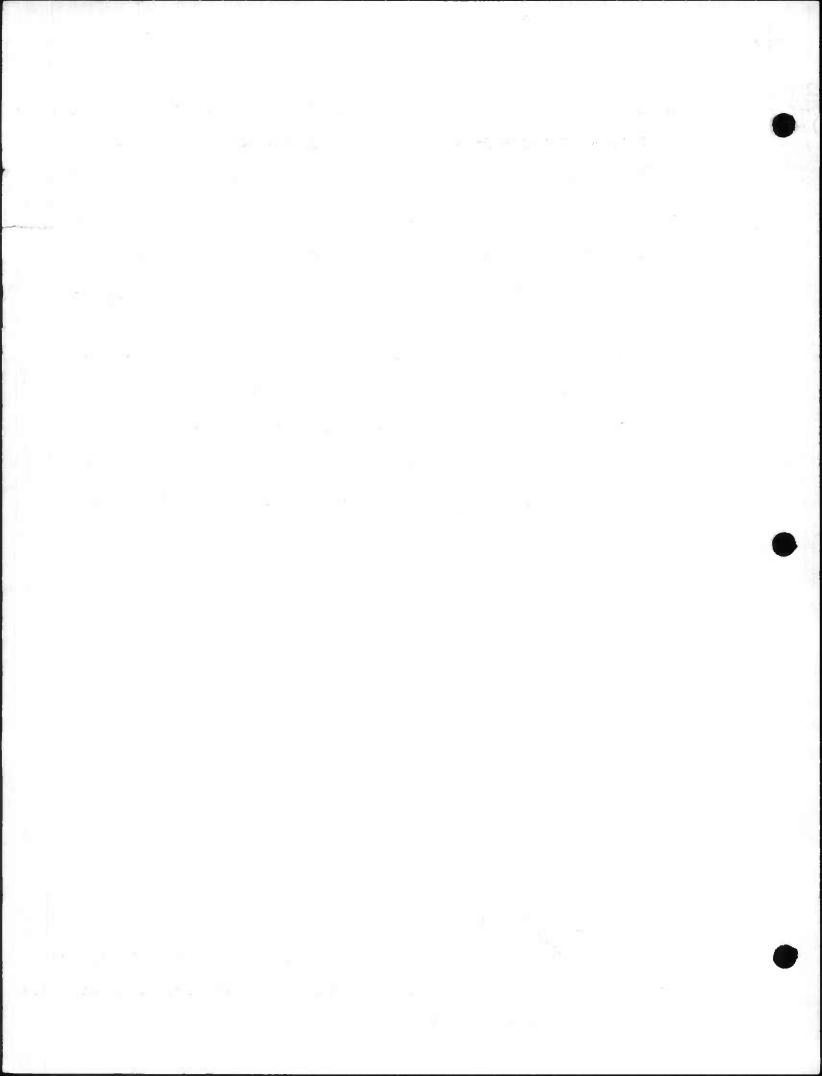
State Registrar

31. Data filed (Month, Day, Year) FEB 1 5 1996

111 Penn Street, Baltimore, Maryland 21201
32. Registrar's Signatura

Fowler

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 🖁 🖔 Certificate of Death 2. Dete of Death Month

Physician /Medical Examiner

Funeral

Director the Maryland ral", or items 23s or 28s-f show

Physician /Medical Examiner

physician and s the burial-transit attending p signed by the a page 2 s cartificata After this funaral death.

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after deat To the Funeral Director: completely filled in by the filled in by the \$

1. Decedant's Nama (First, Middle, Last) 12:04 AM Julia Angotti Caputo 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death BALTIMORE Mays Chapel 414 Rockfleet Rd. Apt. 104 If Undar 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 F 79 232-10-9968 Vre West VA. Sept. 5, 1916 Usual Rasidence of Decedant 10a Steta 10b. County 10c. City, Town or Location 10d, Insida City Limits 1 Yes 2 No Director MARYLAND BALTIMORE TIMONIUM 10e. Street and Number 10f. ZIp Code 10g. Citizan of What Country? Apt. 104 21093 414 Rockfleet Rd. USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, Whita, etc. 1 Never Merried 2 Married 1 Yas 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Gollega (1-4or 5+) n/a Own Home Homemaker 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Rosaria Tarantino Antonio Angotti 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 414 Rockfleet Rd., Apt. 104 Mays Chapel, MD 21093 Frank Caputo 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 17 Floral Hills Mem.Gardens FEB Clarksburg, W. Va. 21. Signature of Plineral Service License 22. Nama and Addrass of Fecility Lemmon march Lemmon Funeral Home of Dulaney Valley, Inc. Lowell M. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not affer the mode of dying, such as cardiac or respiretory errest, and such as cardiac or respiretory errest, and such as cardiac or respiretory errest, and such as cardiac or respiretory errest, and such as cardiac or respiretory errest, and such as cardiac or respiretory errest. Approximata Interval Batween Onset end Death Mypeardid infarction Immediata Causa (Final disaase or condition resulting in death) Dea to (or as a consequence of) Examiner ASCUL Sequentially list conditions, if any, laading to Immadiata cause. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Viral uno carditis 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yas 2 No Be 25. Was casa rafarred to medical 28. Placa of Death (Check only ona) 10

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residance 6 Other (Specify) 1 Yas 2 No 27. Mangar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 8 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 T Homicida 29a. Certifian

(Check only one)

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

Physician

29c. License number

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

David G. Roberts, M.D., 6565 N. Charles St., Suite 405, GBMC Pavillion East 31. Dete filed (Month, Day, Year) 32. Ragistrar's Signatura

State Registrar

Certification:

edical



42. 0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Deeth 10, 1996 501m bruary 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE N/A SINAI HOSPITAL If Under 1 Yaar | If Under 24 Hrs. 6 Say Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 1□M 2□F Yrs. 219-44-9357 87 JUNE 12,1908 INDIANA Usual Rasidence of Dacedant 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No BALTIMORE BALTIMORE 10f. Zlp Coda 10g. Citizan of What Country? 3403 WINTERSET COURT 21208 USA 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yes, Give Yaar or Datas: 13. Wes Dacedant of Hispanic Orlgln? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - American Indian, Black, Whita, etc. 1 □ Navar Married 2 □ Married 1 Yas 2 No Specify: Specify 3 Widowad 4 □ Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15 Dacedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Eiamentery/Sacondary (0-12) Collega (1-4or 5+) HOUSEWIFE OWN HOME 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) UNKNOWN GOLDMAN ANNA **OLSAN** 19a. intormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MR. DAVID L. CARP (SON) 7019 PHEASANT CROSS DRIVE BALTIMORE, MD 21209 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Name of cametery, crematory or other place)
BNAT ISRAEL — 20c. Location - City or Town, Steta 2-12-1996 BALTIMORE, MD 4 Donation 5 Other (Spacify) 21. Signature of Maral Sarvice Licansaa 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23a. Part I. Entar the disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heer feilure. List only one ceuse on each line. Approximata Intarval Between Pulmonary I days Dua to (or as e consequence of Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iter any injury or other traumetic event, the Medical Exerci-

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

the Maryland

death

5. Social Security Number

MARYLAND

12

10e. Street and Numbar

immadiata Cause (Finei

diseasa or condition resulting in death)

11. Meritel Stetus

10a. Stata

Director

Funeral

þ

Completed

Examiner sician and buriel-transit Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disaasa or injury that Initiated avents physician a the buriel 96

U Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics Inneral 24 hours a

Physician/Medical Completed by Be 2 Certification: Medical To the I within 2.
To the F complet

that Initiated avents resulting in daath) Last Part ff. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. Myeloma Myocardial Infanct (10 yrs) 25. Wes cesa rafarrad to medical Hospital: 1 Yas 2 No 1 inpatiant 2 ER/Outpatiant 3 DOA 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Time of 1 Natural 5 Panding 1 Tyes 2 No 2□ Accidant investigation

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

1 Yes 2 No 3 Probably 4 Onknown 24b. Wera eutopsy tindings availabla prior to completion of causa of death? 24e. Wes an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Piaca of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d Dascribe how injury occurred 281. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

23b. Dfd tobacco use contribute to the cause of death?

29a. Cartifiar (Check only one)

3 Suiclde

4 Homicida

12 Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, dete and piece, and dua to the causa(s) and mannar as stated.
2 Medical Examíner: On tha basis of axaminetion end/or investigetion, in my opinion, daath occurred at tha tima, data and piece, end due to the ceusa(s) and manner statad.

29b. Signatura end titla of cartifia

31. Data filad (Moeth, Day, Year) FEB 1 5 1996

29c. License number

29d. Data signad (Month, Day, Year)

of daeth (Item 23e) (Type, Print) 30. Neme and address of person who comp

6 Could not be determined

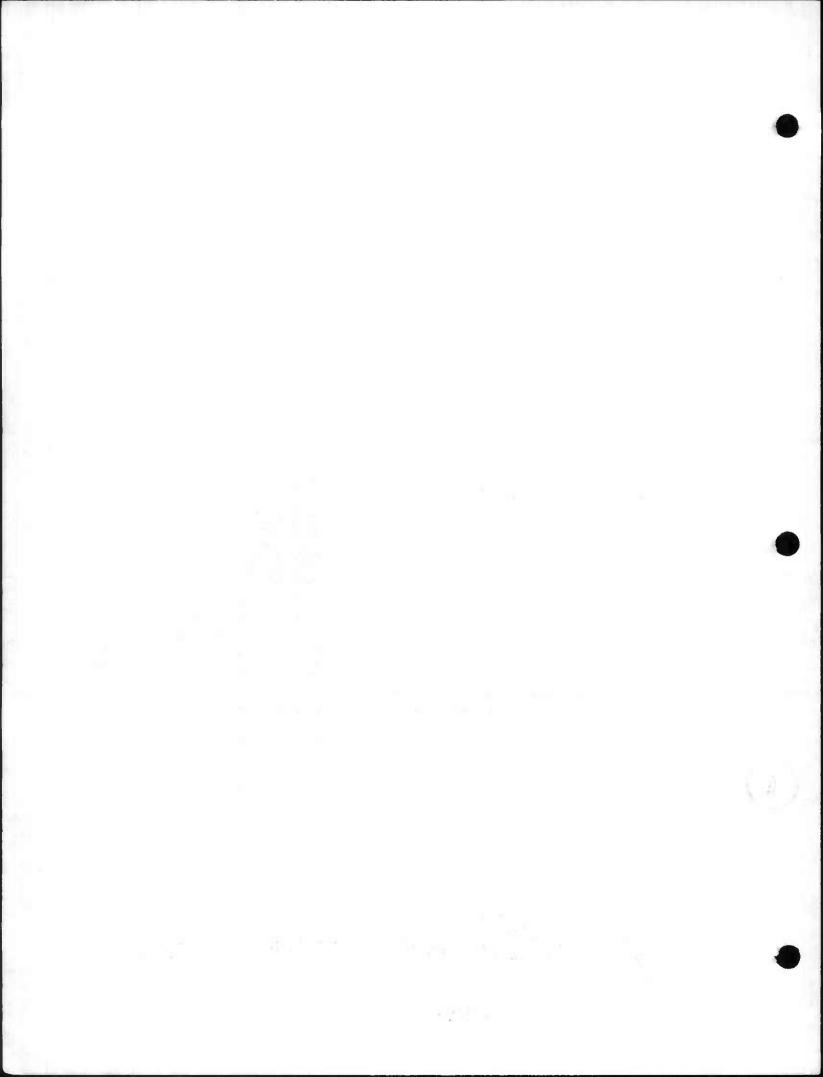
AS 2402321 SINAL HOSPITAL, BALTIMORE, MD

State Registrar

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Cer | tificate of | Death | | Reg. No. | 96 | 03: | 7/1 |
|---------------------|--|----------------|---|---|----------------------------|-----------------------------|---|--|--|------------------------------------|-------------------------------|---|-----------|
| | P1 | | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Dete of De | ath | Ve in | 3. Time ot D | eath |
| | Physic /Medi | | ABRAHAM | STRAU | SS | | COHN | | Month FEB. | 1O | 1996 | 7:02 | PM |
| | Exami | | 4e. Facility Name (If not institution, give | a street and number) | | | | 4b. City, Town, or | Location of Death | | | | |
| | | | SINAI HOSPITAL | | | | | BALTIM | ORE | | N/A | | |
| П | Funeral | | 5. Social Security Number 6. S | | (In yrs. last | | If Under 1 Yeer Months Days | If Undar 24 Hr Hours Mir | | th | 9. Birthpis | ace (State or I | Foreign |
| | Director | | | XXM 2□ F | 82 | Yrs. | , | | SEPT. | 25,1913 | MAF | RYLAND | |
| | B | | Usual Rasidence of Decedant 10a, Stata 10b, County | | 10c. City, To | own or Loc | ation | | | | 10 | d. Inside City | 1 les its |
| | f sho | ō | | N/A | | BALTI | | | | | 100 | 1X Yas 2 | |
| | with the Maryland a or 28a-f show | Director | 10e. Street and Number | | | | 10f. Zip Coda | | | 10g. Citizen of 1 | Mhat County | | |
| | th with 23a or | | 3622 FORDS LA.,A | PT. E | | | | 21215 | | US | | y r | |
| | fter death wi r items 23s | Funeral | 11. Maritel Status | 12. Was Decedent E Armed Forces? | ver in U,S. | 13. W | es Dacedant of I | dispanic Origin? (an, Maxican, Pue | Specify Yes or No | | e - American | | |
| 020 | er, o | þ | 1 Never Merried 2 Married 3 Widowed 4 Divorced | 1 ☐ Yas 2 ☐ No If Yas, Giva A Yaar or Detas: | 0 | | □Yas 2√2No | | nto a nouri, uto.) | Specify | | WHITE | |
| 5-0 | n 72 hours "neturel", | Completed | 15. Decedant's E (Specify only highast gra | ducation ada complated) | 10 | (Giva k | ant's Usual Occup | during most of we | odkina | 16b. Kind of B | usinass/Indu | istry | |
| 121 | filed within Hygiene. ither than | d d | Elementary/Secondary (0-12) | Coilega (1-4or 5- | +) | lifa. D | O NOT use retire | SALESMA | | T | NSURAN | JCE. | |
| 7 | e filed val Hygie other t | | 17. Fathar's Nama (First, Middla, Last | 1 | | | NOOTATIOL | | | | | | |
| Maryland 21215-0020 | S da b > | To Be | HYMAN | <u></u> | (| COHN | | SELM | ama <i>(First, Middl</i> a, 1A | , Maidan Suman | | RAUSS | |
| Var | | | 19a. informant's Name/Ralationship (MRS. BERNICE COR | Type, Print) IN (WTFE) | 1 | | | | Ru <i>ral Rou</i> ta Numb | er, City or Town, | State, Zip C | Code) | |
| | CENE | | | (1122) | | | | A., APT. | | IMORE, | MD 2. | 1215 | |
| 0 | Pages 1 annent of Haanurt: If Item | | 20a. Mathod of Disposition 1XXBurial 2 □ Crametion 3 □ | Removal from Steta | 20b. Place cema | of Dispos Mary, cram | ition (Name of atory or othar pla | ce) | Data | 20c. Location - | City or Tow | n, State | |
| Ħ | tmen tant: jury | | 4 □ Donation 5 □ Othar (Specif | | CHEVE | | AVAS CHE | | 2/11/96 | ROSEDA | LE, MI |) | |
| Baltlmore, | permit. Pages Department of Important: If it any injury or o | | 21. Signeture of Funaral Sarvice Licer | Isee / J./ | | | Name end Addre | | OS., INC. | | | | |
| | 444 | | sidt !!! | unu | ^ | 60 | 10 REIST | ERTOWN F | RD. BALT | O., MD | 21215 | 5 | |
| | | | 23a. Part1. Entar the disaasa, or com shock, or haart tailure. List only | plications that caused to ona cause on each line | tha daath. D a. | o not anta | r tha moda of dyl | ng, such as cardle | ac or raspiratory a | rrest, | 1 1 | Approximeta Intarval Betwe Onset and De | nec |
| 7 | Physician /Medical | | Immediate Causa (Final | | | | | | | | 1 | | |
| | Examiner | | diseasa or condition resulting in death) | a | | | AL INFAF | CTION | | | | 30 MI | NS. |
| | ₽ # | iner | | SEVE | Dua to (or as CRE CO | | | DISEASE | 3 | | | 18 YR | s. |
| ~ | ortificate be specuted ing physician and e as the burla-Iransit | Examiner | Sequentially list conditions, if any, leading to immadiata cause. Entar Undartying Cause (Diseasa or Injury that initiated events | b. ———————————————————————————————————— | Dua to (or as | a consequ | ance of): | | | | | | |
| 68760, | sicia burd | | Cause (Diseasa or Injury that initiated events | c | tue to for es | | anna offi: | | | | | | |
| | tificat or phy as th | Medical | resulting in death) Last | | oua to (or as | a consequ | arios orj. | | | | | | |
| Box | 2 53 | an/Ne | _ | d | | | | | | | | | |
| | 0 0 0 | sici | Part II. Other significant conditions of | ontributing to death but | not resulting | in the uni | dartying cause git | /an in Part i. | 23b. Did | tobacco una co | ntribute to t | the cause of | death? |
| P.0. | es that the death igned by the atte be detached for | Physician/ | | | | | | | 10 | Yes 2 No | 3 Probe | ibly 4 Ur | nknown |
| | th se d | by | CVA, AAA, CATARAC | JIS, DIVERI | TCOLO | 2121 | nerorrn |)TDS/ | | | | | |
| cords, | requires that the been signed by the should be detache | Completed | GOUT, SICK SINUS | SYNDROME, | RETRO | PERIT | ONEAL A | BSCESS, G | CHF 24a. Was | an autopsy rmed? | com | a autopsy tino lable prior to pletion of cau eath? | |
| æ, | 2 2 6 | mo | | | | | | | 10, | Yas 210 No | | Yes 2 No | 0 |
| 配 | 1 A 1 | BeC | 25. Was case rafarred to medical | | | | | 28. Pleca of De | eath (Check only o | | | 100 2211 | |
| - | Physics of the control of the contro | To | examinar? 1 ☐ Yas ※XXNo | Hospitel: 1 🔀 tnpatian | t 2 ER/ | Outpatient | 3□ DOA Oth | Ane: | Homa 5□ Resid | | ar (Specify) | | |
| 0 | ter th | | 27. Mannar of Death 12 Natural 5 □ Panding | 28a. Date of tnjury (Month, Day | | . Tima ot Injury | 28c. Inju | y at | 28d. Dascribe I | how injury occur | red | | |
| Sio | Attending or death. ector: After by the fune | cati | 2 ☐ Accidant invastigation | 1 | | | | Yas 2 □ No | | | | | |
| Division of | or Attending after death. Director: After I in by the fune | Certification: | 3 Suicide 8 Could not be datamined | 28e. Place of Injur building, etc. | ry - At homa, (Specify) | farm, stree | at, factory, office | | 28t. Location (S City or Tox | Street and Numb vn, Stata) | er or Rural I | Route Numbe | 9F, |
| | pital vurs a vurs a rel D | | DOS CONTROL ATTO ALL DE | | | | | | | | | | |
| | Hospita 24 hours Funeral staly filled | edical | 29a. Cartifiar (Check only one) | yatcian: To the best of a | examination : | iga, daath (and/or inva | occurred et tha ti astigation, in my c | na, date end plac pinion, daath occ | e, and due to the surred at the tima, | ceuse(s) and ma data and place, | innar as stat and due to t | ted. he cause(s) | |
| | To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral | Me | 29b. Signature and Mile of certifier | and mapher state | | 1 | 29c. Licens | e number | | 29d. Date signe | d (Month. D. | av. Year) | |
| | - 3 F Ö | |) (1/4 (K | 1/2(1 | de. | _ | | 7748 | | | 186 | ,, ,,,, | |
| | 10 | | 30. Name and address of person who | X | ath /lean no |) (Time D | | 111 | | 4 | , , , | | |
| | 10 | | JOHN HAKIM, MI | 2401 W. | BELV | | | BALTO., | MD 21: | 215 | | | |
| | Sta Registr | _ | FEB 1 5 1996 | 32. Registrar | 's Signatura | | | | | | | | |



Marker Radall

DHMH 16 Rev 6/95

Registrar

Item1 2-15-96 FilmG732 W.H.Per F/H Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

02076

| | | 1. Decedent's Name | ine Th | | | | Death | 2. Data of D | Reg. No. | 3. Time of Death |
|--|-------------|--|--|--------------------------------------|-----------------------------|----------------------------|--|--|--|--|
| Physicia /Medica | | Fr. Ignat | ius Thomas | Norman / | S TE | y Es | | Month | ARY 13, | 1996 605 A1 |
| Examine | er | 4a. Facility Nama (If not institution, g | | CENTER | 2 | | 4b. City, Town, or RANDAL | | | y of Death HUTIMORE |
| uneral rector | | | | e (In yrs. last birthd 79 Yrs | ay) if Unc | ler 1 Yaar s Days | | (Month, D | irth (2ay, Year) | Birthplace (State or Forei Country) KANSAS |
| No. 18 | | 10a. State 10b. County | | 10c. City, Town o | Location | | | | | 10d. Inside City Limi |
| herms 23a or 28a-f show ner must be notified at | ctor | MARYLAND BALTIM | ORE | PIKE | SVILL | Е | | | | 1 Yes 2 N |
| De no | Director | 10e. Street and Number | | | 10f. 2 | Zip Code | | | 10g. Citizen of | What Country? |
| must. | Funeral | 8400 Park Hei | ghts Ave. | Ever in U.S. 1 | 3 Was Day | 212 | 208 Hispanic Origin? (5 | Spacify Vac or N | USA 14 Bar | ce - American Indian. |
| Exam | þ | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes X 1 If Yes, Giva Yaar or Dates: | | If Yes, sp | ecify Cub 2∭ No | oan, Mexicen, Pue | to Rican, etc.) | Bia | ck, White, etc. |
| gcel | eted | 15. Decedent's E (Specify only highest g | | 16a. De | cedent's Us | suai Occu | pation during most of we | orkina | | lusiness/Industry |
| the Me | Completed | Elementary/Secondary (0-12) | Collage (1-4or 5 |) +) | a DO NOT riest | use retire | during most of wo | | Religi | ous |
| 9, | Be C | 17. Fathar's Name (First, Middle, Las | | | | | 18. Mothar's Na | ma (First, Middle | e, Maidan Sumar | |
| | 2 | | land E. Est | tes | | | Estel | la Prui | tt | |
| traum | | 19a. Informant's Name/Relationship | | | _ | | t and Number or R | | | , Stata, Zip Code) |
| y or other to | | Rev. Charles 20a. Mathod of Disposition (C) Buriei 2 Cremation 3 4 Donation 5 Other (Spec | □Ramoval from State | 20b. Placa of Di | spoaltion (N crematory o | lama of rothar pla | - 1 | MD 212 Date 16 FEB. | 20c. Location | - City or Town, State |
| any injury and injury | - | 21. Signature of Euneral Service Lice | 10/1 | noly 1 | | | esa of Fecility | red. | Fikesvi | ile, MD |
| Buy | | Bevan | Clary | 4 | Ler | nmon | Funeral | Home of | Dulaney | Valley, Inc. |
| ician dical niner | | 23a. Part1. Enter the discussa, or cor shock, or heart failure. List only immediate Cause and disease or condition resulting in death) | a. ACUTE | Due to (or as a con | ARD | IAL | | | | Approximata Interval Between Onsat and Death |
| -transit | Examiner | Sequentially list conditions, if any, laeding to immadiata ceuse. Enter Underlying | b | Due to (or as e con | sequenca o | f): | | | | |
| physicia the bur | | ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last | c | | | | | | | |
| for use as | Physician/M | | d | | | | | | | |
| bed fo | SICI | Part if. Other significant conditions | contributing to death bu | ut not resulting in th | e undarlying | ceuse gi | ven in Part I. | 23b. Did | I tobacco use co | ontributs to the cause of deat |
| | by Ph | PERIPHERAL | - VASCH | LAR DI | SEAS | E | | 1 | Y88 2 No | 3 Probably 4 Unkno |
| | Completed | | | | | | <u> </u> | | s an autopsy formed? | 24b. Wara autopsy findings available prior to completion of cause of death? |
| | | 11 | | | | | | 10 | Yes 2 No | 1 Yes 2 No |
| - F | o Re | 25. Was case referred to medical axaminer? | Hospital: 1 Inpatie | nt 2 ER/Outpa | tient 3 🗆 I | Oti Oti | har: | ath (Check only | one) | nas (Engelfel) |
| within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | | 27. Manner of Death Naturai 5 Pending Accident investigation | 28a. Date of injur (Month, Day | y 28b. Tim | e of | 28c. inju Wo | ry at | 1 | how injury occur | |
| | | 3 ☐ Sulcida 8 ☐ Could not l 4 ☐ Homicida datermined | 28a. Place of inju- building, ato | ury - At home, farm, c. (Specify) | streat, facto | ory, office | | | (Street and Numi own, Stata) | ber or Rural Route Number, |
| letely fill | edical | 29a. Certifier (Check only one) 1 Certifying Pi | hysician: To the best of minar: On the basis of end manner sta | examination and/or | ath occurre | d at tha ti on, in my o | me, date and place opinion, death occ | e, and dua to tha urred et tha fime | a cause(s) and ma , date and place, | anner as stated. and dua fo the cause(s) |
| dwoo | Z E | 29b. Signatura and title of certifiar | 15-23-31-23-11-42-2 | | 2 | 9c. Lican | sa number | | 29d. Data signe | ed (Month, Day, Year) |
| | | Danh | nech | me | | D | 30263 | | FEBRUAR | 4 13, 1996 |
| | | 29b. Signatura and fitte of certifiar 30. Name and eddress of person who PANCIS KHOO 31. Date filest/Meanth. Box Vol. 2000. | complated cause of de | eath (item 23a) (Type NORTHW | pe, Print) | 1050 | DITAL | CENTE | R | |
| State | | 31. Date file FEB. 1ay 5 e199 | S Jak Rechard | ir signatur | 1 | | | | • | |

the state of the s

X 68760 BANTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be field detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be field detached for use as the bunal-transit permit.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

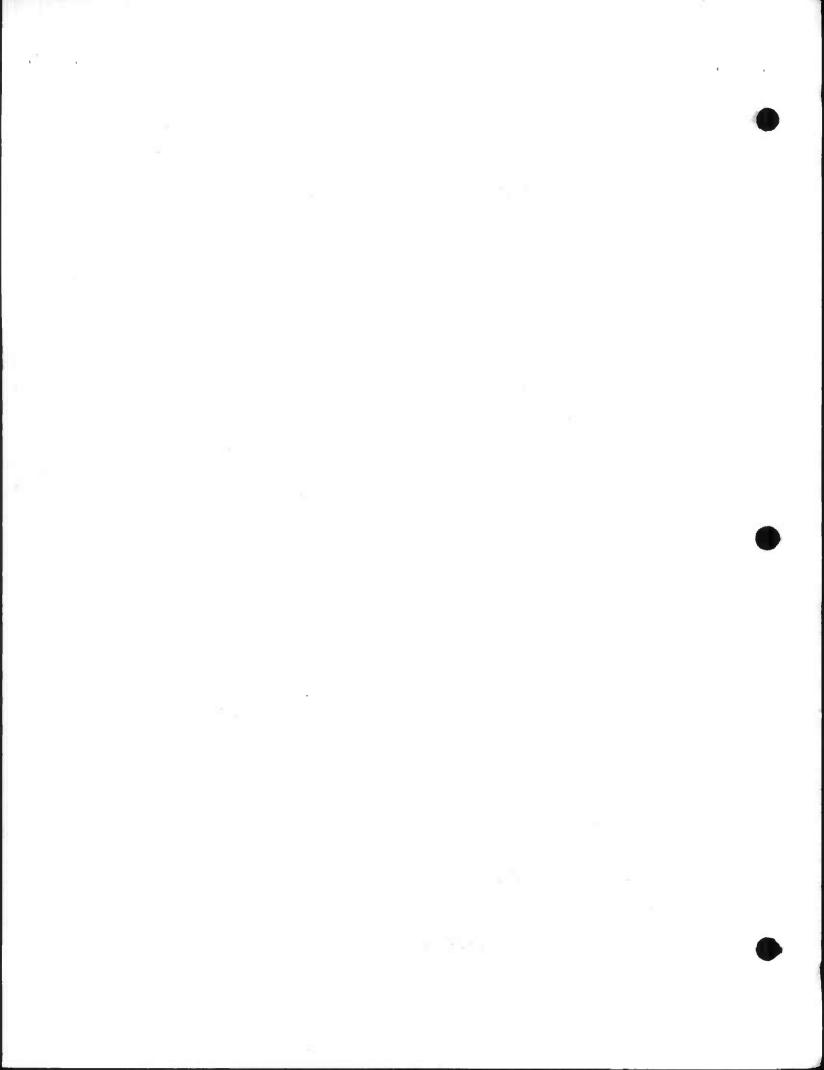
1 - STATE OF M

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

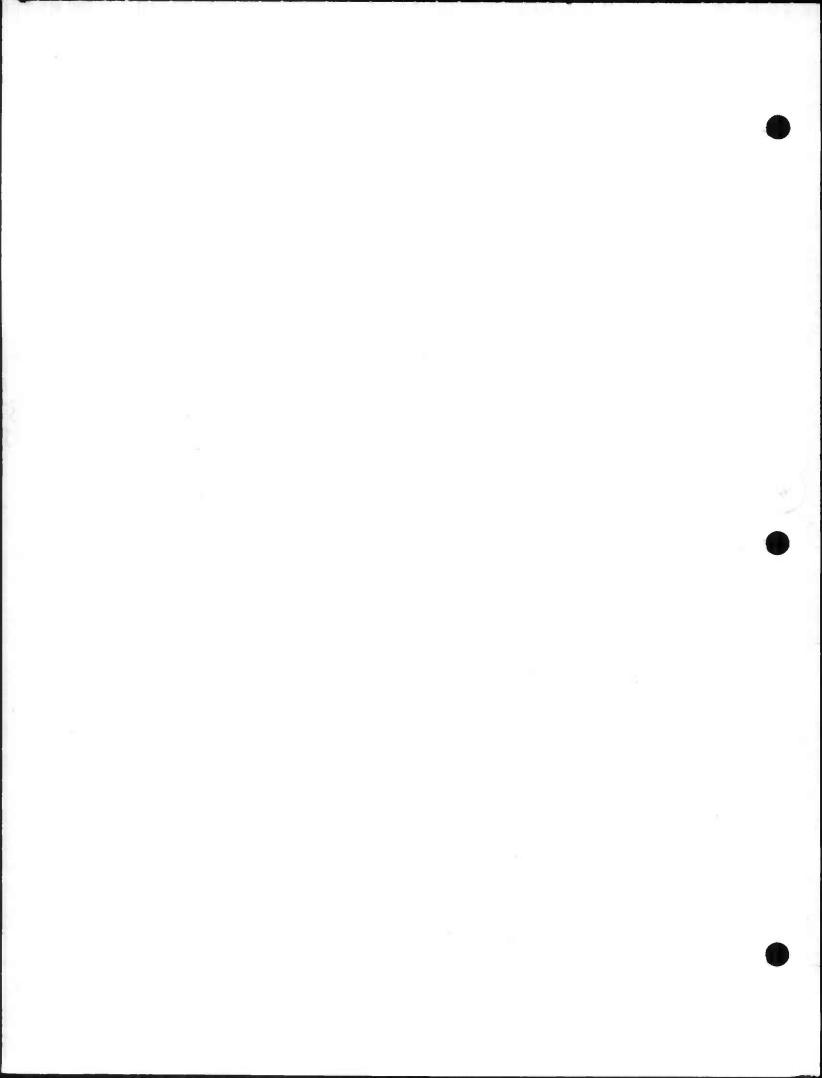
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| James A. Morton & Sons Funeral Home 1701 Laurens St. Balton, MD 21217 23. PART I. Enter(the) diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiredory arrest, shock, or heart failure. List only one cause on asch line. IMMEDIATE CAUSE (Fine) IMMEDIATE CAUSE (| | | | ENSEE | AL | butus | | | | | | SALTO |)., | MD |
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| Compared to the cause of the state of the | YSI | 1 WYES 2 NO | | | ER/Outpatient | t 3 🗆 DOA | | | 10 5 □ Ra | aldence | 6 Other (Specify) | | | |
| Compared to the cause of the state of the | 표 | | Donation . | 28a. DATE OF II (Month, Day | NJURY r, Year) | | | | | | 28d. DESCRIBE HOW | INJURY O | CCURED | |
| 3 Usclide 4 Homicide 5 Could not be determined 288. PLACE OF INDIRY — At home, farm, street, factory, office 288. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMMUTED CAUSE OF DEATH (ITEM 27) (Type, Print) ROWLY 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | М | | | NO | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER D34334 PBrvpry 13 1996 30. NAME AND ADDRESS OF PERSON WHO COMMUTED CAUSE OF DEATH (ITEM 27) (Type, Print) RMT (. G-Unwell 315 N. CALVET 55, Baltimore, MD 31302 31. DATE FILED (Morith, Day, Year) 32. REGISTRAR'S SIGNATURE | | | 28a. PLACE OF building, a | t home, farm, s | street, facto | ory, offic | :0 | | 28f. LOCATION (Stree City or Town, State | and Number | er or Rural R | loute Number, | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER D34334 PBrvpry 13 1996 30. NAME AND ADDRESS OF PERSON WHO COMMUTED CAUSE OF DEATH (ITEM 27) (Type, Print) RMT (. G-Unwell 315 N. CALVET 55, Baltimore, MD 31302 31. DATE FILED (Morith, Day, Year) 32. REGISTRAR'S SIGNATURE | E | | o contaminad | | | | | | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER D34334 PBrvpry 13 1996 30. NAME AND ADDRESS OF PERSON WHO COMMUTED CAUSE OF DEATH (ITEM 27) (Type, Print) RMT (. G-Unwell 315 N. CALVET 55, Baltimore, MD 31302 31. DATE FILED (Morith, Day, Year) 32. REGISTRAR'S SIGNATURE | ᆲ | (Check only | | | | | | | | | | | | |
| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) | Š | 2 MEDI | ICAL EXAMINE | R: On the basis of ax | imination and | /or investigatio | n, In my o | pinion, d | death occur | ad at the | time, data and place, | nd due to t | the cause(a |) and manner as stated, |
| 30. NAME AND ADDRESS OF PERSON WHO COMMETED CAUSE OF DEATH (ITEM 27) (Type, Print) RISHT (. Grennell 315 N. CALVET 55, Baltingre, MD 3/302 31. DATE FILED (Morith, Day, Year) 32. REGISTRAR'S SIGNATURE | ш | 29b. SIGNATURE AND TITLE | OF CERTIFIER | ^ | | | | | 29c. LICE | NSE NUM | IBER | 29d, DA | TE SIGNED | (Month, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RIBUT (. Grenvell 315 N. CALVET 55, Baltinger, MD 2/202 31. DATE FILED (Morith, Day, Year) 32. REGISTRAR'S SIGNATURE | | Kohet (| ZJ rue | well | | | | | 03 | 433 | 4 | DA | Bron | N3131996 |
| 31. DATE FILED (Month, Dey, Year) 32. REGISTRAR'S SIGNATURE | F | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAUSE | OF DEATH (| TEM 27) (Type, | Print) | | | _ | | | | 7 |
| 31. DATE FILED (Month, Dey, Year) 32. REGISTRAR'S SIGNATURE | | Korsuf (. | Green | well | 315 | N. CAL | VENT | - 5 | 5, | Ba | this one | MD | 212 | 02 |
| FFB 1 3 1996 Bulk diwdertark | | _ | | 32. REGISTRAR | 'S SIGNATUR | E | | | | | / | | | |
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| TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours executed within 24 hours executed within 24 hours executed by the hospital process. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the wordor, page 5 should be detached | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF N | IARYLAND / | | | | IEALTH DEAT | | | | _ | | | |
|---------------|--|-------------------------------|----------------------------|-------------------------|---------------|-----------------|----------------|-----------|-----------------------|----------|-------------|---------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | 1 | Ci | HIII | ICAT | E OF | DEAI | п | 2. DATE OF I | EG. NO | | | 3. TIME OF DEATH | |
| 1 1 | | • | | | | | | | MONTH | D | | YEAR | 100000000000000000000000000000000000000 | |
| | TERESA 4. SOCIAL SECURITY NUMBER | 5. SEX | NF. 6. AGE (In yrs. las | 4 6 4 4 4 1 1 | GUR | NEY R 1 YEAR | IF UNDER | | FEBRU 7. DATE OF E | | 08. | 1996 | 11:20 AM M | |
| | | 1 □ M 2 ☑ F | -7.5 | YRS. | MONTHS | DAYS | HOURE | MIN. | (Month, De | y Year) | 1965 | Countr | | |
| | 218-94-2699 | Λ | 30 | rns. | | | | | | 40, | | - | RYLAND | |
| l ~ l | 9a. FACILITY NAME (If not institution, give | | | | 9b. CIT | Y, TOWN | R LOCATIO | ON OF DE | ATH | | | NTY OF D | EATH | |
| 0 | THE JOHNS HOPKIN | NS HOSPITA | L | | BAL | TIMO | RE C | ITY | | | N/ | A | | |
| H | 10e. STATE 10b. COUN | TY | | 10c, CI1 | Y, TOWN | OR LOCAT | TION | | | | | | 10d. INSIDE CITY | |
| DIRECTOR | MARYLAND HAR | FORD | | J.J.A | RRET | TSVI | LLE | | | | | | LIMITS? 1 YES 2 NO | |
| | 10e, STREET AND NUMBER | . 010 | | | | | , ZIP CODE | | | | I son CIT | IZEN OF V | WHAT COUNTRY? | |
| PA | 3507 ADVOCATE HI | IIC DDIWE | | | | 1.0 | 210 | | | | | S.A. | VIIAI COONTRIT | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | EVED IN ILC AD | MED | 1 10 | WMO DEC | | | IIC ORIGIN? (S | | | | | |
| 15 | 1 Never Merried 2 Merried | FORCES? 1 | YES 2X | | 13. | It yes, sp | ecity Cuber | n, Maxica | n, Puerlo Ricar | | or No- | Black | E — American Indien, c, Whita, etc. | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | 1 TYES | 5 X NO | Specify | y: | | | Speci | WHITE | |
| | 15. DECEDENT'S ED | | 18a, DE | CEDENT'S | USUAL | CCUPATIO | ON | | 16b. KIN | D OF BU | SINESS/INI | OUSTRY | | |
| COMPLETED | (Specify only highest grad | | (G | ive kind of Do NOT u | work done | during me | st of workin | g | | | | | | |
| 12 | Elamentary/Secondary (0-12) | College (1-4 or 5+ 2 YEARS | | MPUT | ER A | NALY | ST | | CO | MPUT | ER C | OMPA | NY | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | 4FR'S NA | ME (First, Middl | a Maiden | Surnamal | _ | | |
| | JOSEPH C. FRANKE | NRERGER | | | | | | | M. TAY | | our name, | | | |
| B | 19e, INFORMANT'S NAME (Type/Print) | II DERIODA | 19 | h MAILIN | ADDRES | £ (Street) | | | Route Number, (| | m State 70 | Cadal | | |
| 12 | DONALD A. GURNEY | (HUSBAND | | | | | | | | | | | LE, MD. 21084 | |
| | 20a. METHOD OF DISPOSITION | (HODDIM) | 20b. PLACE | | | | | ו מחי | DATE DATE | | | | | |
| | 1 Buriel 2 Cremation 3 Re 4 Donetion 5 X Other (Specify) | moval from State | | | | | | FIIM | 2/10/96 | | MONT T | | ARYLAND | |
| | 21, SIGNATURE OF FUNERAL MENUCE I | | DOLAN | EI V | | | ND ADDRES | | | 11 | HONT | Jri, I | IAICI LAND | |
| | 21. SIGNATORE OF TONERAL PERFECT | | , | | l s | CHIN | TUNEK | FUN | ERAL H | IOME | OF B | EL A | IR, INC. | |
| | 4/1/-1 | 6-11 | - | | | | | | | | | | MD. 21014 | |
| | 23. PART i. Enter the diseases, or | r complications the | t causad the de | ath. Do | not ante | r tha mo | da of dyl | ng, auc | h as cardiac | or rasp | iratory ar | reat, | Approximate | |
| | 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition recuiting in deeth) Pure To (OR AS A CONSCOUENCE OF): Due To (OR AS A CONSCOUENCE OF): B. Acute M. Constant feliure and feliure | | | | | | | | | | | | | |
| | disesse or condition resulting in deeth) | . Khe | noce | chr | .0 | 1 | 1110 | DYV | nucc | 715 | à | | 12 wk | |
| | resulting in assum, | DUE TO | OR AS A CONSE | OUENCE C | PF): | | | 21. | 1/ | 1 | | | | |
| z | | · Acu | te IV | mil | lor | 2211 | MIN | 0 | Lyen | 401 | mi | ١. | 6 wks | |
| [은] | Sequantially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSE | OUENCE C | F): | 1 | | | | 1 | 1 | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or injury | С. | | | - | | | | | | | | | |
| E | thet initieted eventa | DUE TO | (OR AS A CONSE | DUENCE C | OF): | | | | | | | | | |
| CERTIFICATION | resulting in deeth) LAST | d | | | | | | | | | | | | |
| | PART II. Other eignificent condition | one contribution to | death but not a | regulting | In the :: | nderlyla | n ceries : | niven in | Part I no | WAS AN | AUTOPSY | 201 | . WERE AUTOPSY FINDINGS | |
| CAL | A - A - A - A |) | | esuiting | _ | | g ceuse (| Jiven in | Pert 1. 24 | PERFO | | 240 | AVAILABLE PRIDR TO | |
| | mostry of | lym f. | hone. | / | 90 | 3 | | | 1 | YES 2 | 2 DINO | | OF DEATH? | |
| MED | - 1 | 1 0 | | | | | _/ | | | | | | 1 TYES 2 NO | |
| ž | DID TOBACCO USE CON | TRIBUTE TO CA | | | | NO 🛚 | UNC | ERTAI | N | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | CE OF DEA | OTHE | | | | | | | | | |
| S | 1 TES 2 NO | 1 inpatient 2 | ER/Outpatient 3 | □ DOA | | | 10 5 🗆 Ra | eldenca | 8 Other (Sp | ecify) | | | | |
| 금 | 27, MANNER OF DEATH | 28e. DATE OF (Month, D | | 26b. TII | ME OF JURY | 28c. IN. | JURY AT | | 28d. DEŞCRI | BE HOW | NJURY OC | CURED | | |
| BY | 1 Action 5 Pending Investigation | | | | М | | YES 2 | NO | , | | | | | |
| ED E | | | | | | | | | | | | Route Number, | | |
| | 4 Homicide determined | | | | | | | | | | | | | |
| " | 29a, CERTIFIER 1 CERTIFYING PHY | SICIAN: To the best of | my knowledge, de | ath occur | red at the | time, date | end plece | , end dua | to the cause(s |) and ma | nner as sta | ted. | | |
| COMPLET | and and | | | | | | | | | | | | i) end manner es stated. | |
| | 29b. SIGNATURE AND LITTLE OF CERTUR | | | | | | | ENSE NUI | | | _ | | | |
| H | St.V. In. 16 | Made - | | | | | A 1 | 70 | CU | | Eva. UA | -/. | (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CALL | RE OF DEATH #TF | M 27 /5:- | o Doi-11 | | 1 | ~ 8 | 0 / | | 1 - 1 | COTO | 1919 8 /916 | |
| | 11/ |), IA | OF DEATH (ITE | | | , , 1 | 1 - | .1 | D. 11 | 1 = | _ | 750 | | |
| | 31 DATE EN ED (Month Day Voor) | Kmanill | P 60 | N | 1. 1 | VOL | Ge 5 | ブ. | 150 /14 | moz | R. C | 100 | | |
| | FEB 1 5 1996 | di dinas | readell | | | | | | | | | | | |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

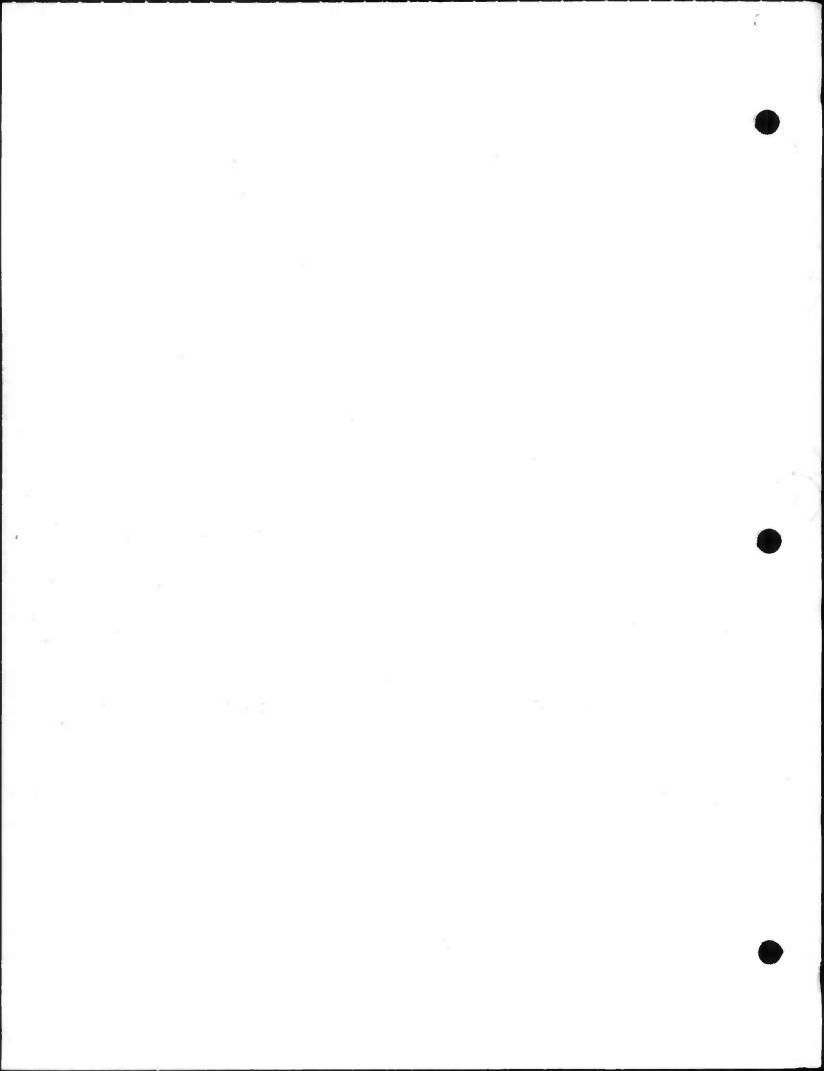
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | |
|---------------|--|------------------------------|
| | 1. DECEDENT'S HAME (First, Middle, Leat) | OF DEATH |
| | TORIA A (O.I.D. (O.I.) MONTH DAY YEAR | |
| | 1 ED. 12 1148 3.1 | 00 a. m |
| | O10 -211 1300 15 and Mark House Trans. Funder 12 area. (Month, Day Was) Country). | State or Foreign |
| | 1 5-10-33 MGG | yland |
| _ | 9a. FACILITY HAME (If not institution, give street and number) 8b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | |
| Q. | 366 S. FORTHILL AVE. BOLLINGE NORCE | |
| 5 | RESIDENCE OF DECEDENT | |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INC. | SIDE CITY MTS? |
| | | ES 2 NO |
| AL | 104. STREET AND HUMBER 101. ZIP CODE 109. CITIZEN OF WHAT CO | UNTRY? |
| FUNERAL | 355 S. Footbill Ave. 217.23 105A | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE — American Status) | dean Indian |
| | 1 Never Merried 2 Merried FORCES? 1 YES 2 HO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, | atc. |
| BY | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES" 1 YES 2 ON HO Specify: Specify: | and |
| COMPLETED | 15. DECEDENT'S EDUCATION 186. DECEDENT'S USUAL OCCUPATION 186. KIHD OF BUSINESS/IHDUSTRY | 400 |
| E | (Specify only highest grade completed) (Give kind of work done during most of working | |
| 7 | Elementary/Secondary (0-12) College (1-4 or 8+) College (1-5 or 8+) | |
| Ĭ. | 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maidan Surgama) | |
| | To the time to the | |
| H | Kaymond Jones Dorothy Thomas | 5 |
| 6 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILIHO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | |
| - 1 | Anita Newkick 3500 Sussex Kd. Ballimore Md. 21 | 207 |
| | 20a METHOD OF DISPOSITION 1.0 Burlel 2 Cremation 3 Removal from State 20b. PLACE AHD DATE OF DISPOSITION (Name of Company of other plane) | |
| | 1.0 Burial 2 Cremation 3 Removal from State cametery, crematory or other piece) 4 Donation 5 Other (Specify) FGIVIEW United Market | MJ. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF EACH ITY | 110000 |
| | Derrick C. Jones Fureral | HOLK |
| | John D. Jakyan My 46/1 Park Heights AVE. | |
| | 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, abock, or heart failure. List only one cause on each line. | proximata |
| | 1 111 | terval Batween |
| | disease or condition Coron and the zone holid | uddey |
| | | death |
| | - Atheroicle Totic heart disease | 4 / |
| CERTIFICATION | Sequentially flat conditions, | u de ter |
| A | If any, leading to immediate cause. Enter UNDERLYING | |
| 윤 | CAUSE (Disease or Injury | |
| Ē | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | - 1 |
| 剪 | d | |
| | PART II. Other algoriticent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AL | TOPSY FINDINGS |
| MEDICAL | PERFORMED? AMILABI | LE PRIOR TO TION OF CAUSE |
| | 1 YES 2 THO OF DEAT | |
| Σ | | 8 2 🖒 HO |
| Ž. | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN | |
| 3 | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: | |
| S | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Hursing Home 5 Residence 6 Dther (Specify) | |
| PHYSICIAN: | 27. MAHHER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. IHJURY AT 28d. DESCRIBE HOW IHJURY OCCURED | |
| ВУ Б | 1 Hours 5 Pending (morns, pay, rear) HOURY WORK? | - 1 |
| | 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 28t LOCATION (Street and Mumbes or Burn) Greet Atua | *** |
| | 6 Could not be building, etc. (Specify) 4 Homicide determined | Dev, |
| COMPLETED | 29a. CERTIFIER | |
| <u>a</u> | (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | |
| ő | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mer | mer as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, D | lay Year) |
| BE | William PO 75 32 Dec bigner 1200. License number 200. Date signed (Month, C) PO 75 32 | 1996 |
| 2 | THE MANUE AND ADDRESS OF ASSAULT AND ADDRESS | 1110 |
| | Yelena Lipnik 900 Catou tve Baltimore MD 212 | 29 |
| | | 4 (|
| | H /. A A | |
| | FEB 1 5 1996 And Shucker Roylett | |



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| | V.H.Per | F / | н | State of N | nai yiai iu | | rtificate of | | iviental Hy | Reg. No. | | | | | | |
|------------|---|----------------------------|--|---|-----------------------------------|----------------------------|---|---------------------------------------|---|-------------------------------------|--------------------------|--|--|--|--|--|
| 10 | Physic /Medi | | Decedent's Nama (First, Middle, L GEORGE | George | e Thort | on Go | oode | | 2. Deta of Do Month FEBRUAR | Dey | 996 | 3. Time of Deeth 0600 A.M. | | | | |
| 7 | Examir | | 4e. Facility Name (If not institution, g | ive street end numbe | r) | | | 4b. City, Town, o | r Location of Deal | th 4c. Count | y of Death | | | | | |
| | | | NORTH ARUNDEL HO | | | | | GLEN BUR | | | ARUN | IDEL | | | | |
| | Funeral Director | | 578-10-0379 | Sex 7. A 1 XM 2 F | Age (In yrs. las | Yrs. | If Under 1 Yaar Months Deys | | | irth ey, <i>Year)</i> 1916 | 9. Birthi Cou VIRG | placa (State or Foreign ntry) GINIA | | | | |
| | puel # # | | Usuel Residence of Decedant 10a. Stata 10b. County | | 10c. City, | Town or Lo | cation | | | | Τ, | 10d. Inside City Limits | | | | |
| | Manylen -{ show | To | MARYLAND ANNE AF | HINDEL. | CR | OWNSV | TLLE | | | | | 1 ☐ Yes 2 🛣 No | | | | |
| | h the | Director | 10e. Street and Number | | J. Oit | 0112101 | 10f. Zlp Code | | in the second | 10g. Citizen of | What Cou | ntry? | | | | |
| | h wit | a D | 1030 DOCKSER DRIV | Æ. | | | | 21032 | | U.S | .A. | | | | | |
| 21215-0020 | s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mentai Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercites than the notified at | by Funeral | 11. Marital Status 1 Never Merried 2 Married 3/04/Widowed 4 Divorced | 12. Wes Decedan Armed Forces 1 Yes 2X If Yes, Giva Yeer or Detas | 1? X No | 1 | Wes Decedant of F f Yes, specify Cub | | (Specify Yas or Norto Rican, etc.) | o- 14. Re Ble Specia | ick, White, | can Indian, , etc. | | | | |
| 0 | 2 hou | Pe | 15. Decedent's 8 | ducation | | 16a. Deced | dent's Usual Occup | pation | | 16b. Kind of B | | | | | | |
| 215 | hin 7 9. In n | Completed | (Specify only highest gi Elemantary/Secondery (0-12) | rada completed) College (1-4or | (5+) | (Give life. L | kind of work done DO NOT use retire | during most of w | orking | | | | | | | |
| | filed with Hygiene. ther ther | Corr | 12 | N/A | | | OWNER | | | MACHIN | IST | | | | | |
| Maryland | be fill d oth even | Be | 17. Father's Nema (First, Middle, Las | | | | | | eme (First, Middle | - 1112 | 11 | lealey | | | | |
| N S | should be and Mental I marked of umetic eve | 1º | GEORGE | Н. | | | OODE | GRACE | | MAY | | HEARLY | | | | |
| Mai | 12 sho h end 7 is me | | 19a. Informant's Neme/Reletionship | (Type, Print) | | | ng Address (Street | | | | | | | | | |
| | 1 and 2 Health em 27 I | | JAMES W. GOODE | | | | AIRVIEW . | AVENUE, | Data | 20c. Location | | 21090 | | | | |
| Baltimore, | Pegenent of | | 1 X Buriel 2 ☐ Cremetion 3 I 4 ☐ Donation 5 ☐ Other (Spec | ify) | e cerr | LING | natory or other ple CEMETERY Nama and Addre | | 2/17/96 | | | | | | | |
| Bal | permit. Peg Department Important: I any Injury o | | 21. Signeture of Funeral Service Up | FUNERA BURNIE | L HOM | IE RYLAND, | | | | | | | | | | |
| | | | 1 SECOND AVENUE S.W., GLEN BURNIE, N 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. | | | | | | | | | | | | | |
| 7 | Physician /Medical Examiner | | Immediate Ceuse (Fine) disease or condition resulting in deeth) | · Pulm | onaru | Ea | lema | | | | 1 | Interval Between Onset and Deeth | | | | |
| Box 68760, | death certificate be executed e ettending physician and ad for use as the burial-transit | Physician/Medical Examiner | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disease or Injury that initieted events resulting in death) Last | b. Corono | | Y teri | uence of): | ease | | | | | | | | |
| | U W X | sicla | Pert II. Other significant conditions | contributing to death | but not resulti | ng in the ur | nderlying causa gir | ven in Part f. | 23b. Did | tobacco usa co | ontribute t | to the cause of death? | | | | |
| P.0 | es that the death igned by the ette be deteched for | Phy | ~ t | | | | , , , | | | Yes 2 No | 3 Pro | | | | | |
| | de de th | by | Dementia | | | | | | - | | | / | | | | |
| Records, | e law requires that the hes been signed by th ge 2 should be deteche | Completed | | | | | | | 24a. Was perf | s en autopsy ormed? | av | Vere autopsy findings vallable prior to ompletion of cause deeth? | | | | |
| = | 0 - 0 | Con | | | | | | | 10 | Yas 2 No | 11 | □Yes 2X No | | | | |
| 1 | raiclant: The continuate director, pag | Be | 25. Wes case referred to medical axeminer? | | | | | | eeth (Check only | one) | | | | | | |
| F | 18 18 18 | 2 | 1 ☐ Yes 2 1 No | Hospitel: 1 Ainpat | | VOutpatien | I SLI DOA | | Homa 5 ☐ Res | idence 6 🗆 Ot | her (Specia | (y) | | | | |
| John S | tending Ph Jeen tor: Alte the funeral | Certification: | 27. Menner of Deeth 1 SNetural 5 Pending 2 Accident Investigation | | ury 2! | 3b. Time of Injury | Wo | ryat rk?]Yas 2 □ No | 28d. Describe | how Injury occu | rred | | | | | |
| Divisi | s after dee il Director: ed in by the | Sertific | 3 Sulcide 8 Could not 4 Homicide detarmined | 28e. Place of Ir | njury - At home rtc. (Specify) | e, ferm, str | eet, fectory, office | | | (Street and Num own, Stete) | ber or Run | al Route Number, | | | | |
| | To the Hospital or Attentwith 24 hours after deel To the Funeral Director; completely filled in by the | edical | 29e. Certifier (Check only one) 1 Certifying P | hysician: To the besi miner: On the basis end menner s | of examinetion | dge, deeth r end/or inv | occurred at the tivestigetion, in my o | me, dete end ple opinion, deeth oc | ce, end due to the curred et the time, | ceuse(s) and m , date and plece, | anner as s | stated. o the cause(s) | | | | |
| | To the To the Complex | Σ | 29b. Signeture end title of certified | · · · · · · | | | 29c. Licens | se number | | 29d. Deta signe | ed (Month, | Dey, Year) | | | | |
| | | | Drelly | | | | D 38 | 958 | | 2/11 | +/86 | 5 | | | | |
| | 20 | | 30. Name and eddress of person who | completed cause of | deeth (Item 2 | 3a) (Type, | Print) | | | 1 | 1 | | | | | |
| | Sta | te | DALJEFT S. SIDHU 31. Dete filed (Month, Day, Year) | 32 Regist | trer's Signatur | 0 | S ROAD, | #106 ODE | NTON, MA | RYLAND | 21113 | | | | | |
| | Registr - | ar | FEB 1 5 1996 | Julianta | welson Ro | really | | | | | | | | | | |

DHMH 16 Rev 6/95

m r and m Satter of Pt.

F. 10 19 1 0 1 1 1 1

Items 7, 8 2-15-96 Film G732 W. H. De F/H. Assure All Copies Are Legible. ITEM: 4. PER F.H. FILM G-732 State of Maryland / Department of Health and Mental Hygiene 96 2/27/96 t.t Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Raymond Emanuel Greene February 1996 4:59 A. /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deal **Examiner** Medical Center Baltimore 5. Social Security Number 227-36-2370 277 Usuel Residence of Decedent If Under 1 Yeer | ff Under 24 Hrs. | Months | Deys | Hours | Min. | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Fountry) 8. Dete of Birth **Funeral** Deys NZM 2DF July Yrs 62 6 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Martiel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahrway injury or other traumatic avant 10e. Stete 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Director timore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 820 Funeral 21229 Wes Decedent Ever in U,S. Armed Forces? 1 Pyes 2 □ No Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 11. Meritei Stetus 1 ☐ Never Merried 21 Merried 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Middle, Last) Be 2 19a. Informant's Name/Reli 1 Burial 2 []() 3 [Removel from State metion 4 Donation Other (Specify) ese, or compilications that caused the deeth. Do not enter e. List only one cause on each line. the mode of dying, such es cardiec or respirat **Physician** /Medicai Immediale Ceuse (Finei disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the burlei-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Physician/Medical Due to (or es e consequenca of): USe es Pert fi. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? aigned by t 1 Yes 2 No 3 Probably 4 Unknown Completed by e fill been a 24b. Were sutopsy tindings svallable prior to completion of cause of death? 24a. Wes en autopsy performed? Ne law red 1 Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After held. 25. Wes case reterred to medical exeminer? Be 28. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28c. Injury at Work? 28a. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigetion 1 Neturei 1 Yes 2 No 2 Accident completely filled in by the 3 Suicide 6 Could not be determined 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end pieca, end due to the cause(s) end menner stated. Medical 29e. Certifier 29b. Signature end title of certifle 29c. License number 29d. Date signed (Month, Day, Year) AU41764735A3ZZIS 56 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

Alejandro Rodrigues, M.D., 1000 Fell Street, Baltimore, MD 21231

82. Registrer's Signeture

State Registrar 31. Dete filed (Month, Dey, Year) FEB 1 5 1996

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760,

Division of Vital

. 2 1 - FOR STATE REGISTRAR

| | | 1. DECEDENT'S NAME (First | , Middle, Last) | | ,1 | | | | | | 2. DATE OF DEATH MONTH D | | YEAR | 3. TIME OF DEATN |
|---|--------|---|---------------------------------|-----------------------------|------------------------------|----------------------|---|-------------|------------------------|------------|---|------------|--------------------------|--|
| | | Thomas | C. | | Her | nde | NSOU | 7 | | | | 0 | 76 | 12 20 Pm |
| 1 | | 4. SOCIAL SECURITY NUME | ER | 5. SEX | 6. AGE (In) | | MONTHE | DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) | | 8. BIRTN Country | PLACE (State or Foreign |
| 목 | ļ | 219-74-5 | 966 | 1 M 2 D F | 3 | | RS. | | | | 04-05- | | Ten | n. |
| 3 should | œ | 0 | | treet and number) | , 20 | 500 | 96. CIT | | OR LOCATIO | | i. | 9c. COU | NTY OF DI | |
| . 2, | CTOR | RESIDENCE OF DEC | DUR | tospit. | el. WI | Salty | 2 St | 150 | ltera | ine | MD | | N/A | |
| sages | DIREC | 10e. STATE | 10b. COUNT | | | 10 | c. CITY, TOWN | | | | | | | 10d. INSIDE CITY LIMITS? |
| # | | MD. | 1 | N/A | | | Ва | | more | | | | | 1 FYES 2 NO |
| it permit. | RAL | 100. STREET AND NUMBER | ldish | Avenue | | | | 10 | 2121 | | | 10g. CIT | U.S | HAT COUNTRY? |
| physician. burial-transit | FUNE | 11. MARITAL STATUS | 101311 | 12. WAS DECEDEN | T EVER IN U | I.S. ARMED | 13 | . WAS DE | | | IC ORIGIN? (Specify Yes | or No- | | - American Indian, |
| | | 1 Never Married 2 | | FORCES? 1 IF YES, GIVE W | YES AR OR DATE | 2 NO | | If yes, s | | ı, Mexicai | n, Puerto Rican, etc.) | 90011540 | Specif | , White, etc. |
| attending se as the |) BY | 3 Widowed 4 Divo | | | | | | | | | | | | Black |
| _ 3 | ETED | (Specify on | EDENT'S EDU ly highest grade | CATION completed) | 10 | (Give ki | ENT'S USUAL ind of work done NOT use retired. | e during m | ION lost of working | g | 166. KIND OF BU | SINESS/INI | DUSTRY | |
| ي ي | PLE | Elementary/Secondary (I | 0-12) | College (1-4 or 5 | ·) | | hine | | ratoi | r | Coco-C | Cola | Co. | |
| detached once. | COMPL | 17. FATHER'S NAME (First, A | fiddle, Last) | | | | | -1- | | | ME (First, Middle, Malden | | | |
| 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 | ш | Hal T. H | lender | rson | | | | | Ha | arri | lette Bro | own | | |
| 5 should notified | 0 B | 19a. INFORMANT'S NAME (| | | | | | | | | Route Number, City or Tow | | | 216 |
| de ne pe ne | | Loretta F | | rson | 1 | - | | | | ave. | . Balto. | | | .216 |
| age 6 may be director, page er must be | | 1 Burlel 2 Crematic | on 3 🗆 Rem | oval from State | | | SVIII | | | Cen | | cation - | | lle,MD. |
| al dire | | 21. SIGNATURE OF FUNERA | | CENSEE | | 001 | | | AND ADDRES | | | | | od Ave. |
| ter death. Pag the funeral dir oval. al examiner | | Vem | mR | Baile | | | / V | | | | ailey F/S | S Ba | lto. | , MD21215 |
| in by r rem | | 23. PART i. Enter the d shock, or h | liseeeee, or leart fallure. | complications the | coused t | he deeth. h line. | Do not ente | er the m | ode of dyle | ng, sucl | h se cerdiec or resp | iratory er | rest, | Approximete Interval Between |
| - 45 | | IMMEDIATE CAUSE (Fill disease or condition | nal | M | nn go | L. | /< | 2 PSI | | | | | | Onset and Death |
| ted writim 24 completely fill ial, cremation. | | resulting in death) | \rightarrow | a. DUE TO | 11ngu | ONSFOLIE | VCE OF | PSI | 7 | | | | | TURKY |
| 8 2 3 | _ | | | . A11 |) < | | 000 | | | | | | | Het |
| 8 " o F | CATION | Sequentially list condit if any, leading to imme | diata | DUE TO | (OR AS A C | ONSEQUEN | NCE OF): | | | | | | | |
| physician ne prior t | | cause. Enter UNDERLY CAUSE (Disease or Inju | | C. DUE TO | (OR AS A C | ONCEOUEN | ACE OF | | | | | | | |
| death certificate attending physical Hygiene prival Hygiene prival ty, or other | ERTIFI | that initiated events resulting in death) LAS | т | | (On AS A C | ONSECUE | TCE OF): | | | | | | | |
| the death y the atten d Mental h injury, o | O | BART H ON | | g, | 4 | | 444 | | | | 1 | | , | + |
| 1 20 1 | EDICAL | PART II. Other algnifica | srit condition | e contributing to | death but | not resu | iting in the | underlyk | ng cause g | iven in | PERFO | RMED? | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| ures the signed Health a | EDÍ | | | | | | | | | | 1 TYES : | DAG | | OF DEATH? |
| show | Σ | DID TOBACCO U | ISE CONT | RIBLITE TO CA | USE OF | DEATH | YES 🗆 | NO. | 7)UNC | FRTAIN | <u> </u> | | | 1 - YES 2 - 10 |
| The law te has b ate Dept. | IAN | 25. WAS CASE REFERRED 1 | | 100 | | | F DEATN (Chec | | | | | | | |
| | SICI | 1 VES 1 NO | | HOSPITAL: 1 Hepatient 2 | ER/Outpeti | ient 3 🗆 E | OTHI | | me 5 □ Ra | sidence | 8 Other (Specify) | | | |
| this certification with the St. | РНҮ | 27. MANNER OF DEATH | 2020 | 28a. DATE Of (Month, C | INJURY Pay, Year) | 28 | b. TIME OF | 28c. IN | JURY AT | | 28d. DESCRIBE NOW | INJURY OC | CURED | |
| After this death with marked | ΒY | 1 Matural 5 2 Accident | Pending Investigation | - | | | М | | YES 2 | NO | | | | |
| 0 4 0 | E | 3 Suicide 8 4 Homicide | Could not be detarmined | 28e. PLACE 0 building, | of INJURY — atc. (Specify | At home, | farm, atroot, fo | ictory, off | lce | | 281, LOCATION (Street City or Town, State | | r or Au ral F | Route Number, |
| OR ATTENDING DIRECTOR: After hours after death item 28 is ma | LET | 29a. CERTIFIER | THEY HAVE BLAVE | CIAN: To the Col. | my basents | ina da-sh | 000mmd 4* | Here 1 | | | to the account to | | | |
| 3 3 Z = | COMPL | anal | HOAL EXAMIN | D | | | | | | | to the cause(s) and ma time, date and place, a | | |) and manner as stated. |
| DIS PARTANT | 出 | 290. SIGNATURE AND TITLE | OFICENTER | * 4 L | | 1 | | | 29c. LICE | 22 | ABER | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 9 | 2 | M. NAME AND ADDRESS O | F PERSON W | 19 COMPYETED CAU | SE OF DEAT | HITEM 27 | (Type, Print) | 05 | 11 | 2 | | 2 | - / / | 1011 0 |
| | | 1807U SECO | uris | Nesp | raf | | ere | OF | INC | 11)(| CING | 200 | Pu | Calmore S |
| 241 | | FFR 1 5 1996 | | 32. REGISTRA | RH S SIGNAT | UHE | | | | | | 21 | 22 | 3 |
| 100 | | LEDT N 1996 | - Colu | A STATE OF THE PARTY OF | and the | | - | | | | | | | DHMH.1/I Bev 1/89 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

. • 5 12

TO BE COMPLETED BY FUNERAL DIRECTOR

| er death. Page 6 may be retained by the hospital or attending physician. | the funeral director, page 5 should be detached for use as the burial-transit per rai | examiner must be notified at once. | |
|--|--|--|--|
| TO THE HOSP M. ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUND AND THE THINK THE THE COURT HAS been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per has the burial-transit per smooth | IMPORTANT IN THE 24 IN marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
| TO THE HOSP | TO THE FUNE | IMPORTANT | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|--|--|--|----------------------------|--|----------------------|-------------------|---------------|-----------|---------------------------------------|
| 1. DECEDENT'S NAME (FIRST, MIDDIO, LOST) FLORENCE H | YMAN | | | | 2. DATE O MONTH | | 1996 | AFI | 7:15 Am |
| 4. SOCIAL SECURITY NUMBER 214-01-2381 | 7 | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE C (Month, | | 6. 8 | INTHPLA | ce (State or Foreign |
| 90. FACILITY NAME (If not institution, give a SIMAI HOSPITAL | | 96. | | R LOCATION OF DE | | | 9c. COUNTY | | |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | ν | I so CITY TO | OWN OR LOCAT | 1041 | | | | 7 | 1. INSIDE CITY |
| Maryland N/ | | | Baltim | ore | | | | × | XYES 2 NO |
| 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | | 10g. CITIZEN | | |
| 6317 Park Height | s Ave Apt 3 | | 40 11110 0550 | 21215 | | | | U.S | |
| 1 Never Merried 2 Merried | FORCES? 1 YES | 2 V VIO | If yes, spe | ENDENT OF HISPAN ocify Cuben, Mexican | n, Puerto R | | | Black, Wi | Americen Indien, hite, atc. |
| Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 TYES | 2 XX Specify | r: | | | Specify: | White |
| 15. DECEDENT'S EDU | CATION | 16e. DECEDENT'S USU | JAL OCCUPATION | DN | 18b. | KIND OF BUSI | NESS/INDUST | RY | WIITE |
| (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use rel | done during mo. tired.) | st of working | | | | | |
| 12 | | Case Wo | rker | | Ba | altimor | e City | y So | cial Serv. |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAI | ME (First, M | fiddle, Maiden Si | umame) | | |
| Joseph | | Weinstein | | Be | tty | | (| Cohe | n |
| 19e. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural F | | | | | |
| <u>.</u> | aughter) | 18 Bee | hive P | lace Ap | t B, | - | | | D 21030 |
| 20e. METHOD OF DISPOSITION t XBurisi 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | | b. PLACEAND DATE OF D metery, cremetory or other BALTIMORE H | | | 1/96 | | sters | | 200 |
| 21. SIGNATURE OF FU ERAL SERVICE LI | CENSEE | 1 | | D ADDRESS OF FAC | | | | | |
| Acath 11 | 1 Carth | d | 6010 | Sol Levi Reisters | town | Rd, Ba | ltimo | re, | MD 21215 |
| 23. PART I. Enter the diseeses, or shock, or haert fellure. | complications that cause Liet only one cause on e | d the death. Do not a | enter the mo | de of dying, suci | h ss card | isc or respire | atory srrest, | | Approximats Intervel Between |
| IMMEDIATE CAUSE (Final disease or condition | Sentic | Shock | | | | | | | Onset and Desth |
| resulting in deeth) | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | | Weeks |
| Construction and Construction | Preuron | 14 | | | | | | | Weeks |
| Sequentielly list conditions, If sny, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF); | | | | | | | |
| ceuse. Enter UNDERLYING CAUSE (Disease or Injury | c | | | | | | | | |
| that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | | |
| resolving in deathy EAST | d | | | | | | | | |
| PART II. Other significant condition | ne contributing to deeth | but not resulting in ti | he underlying | g ceuse given in | Part I. | 24a. WAS AN A | | | RE AUTOPSY FINDINGS |
| RREAST ADEN | O CAPLINONA | | | | | PERFORM | | co | AILABLE PRIOR TO MPLETION DF CAUSE |
| | | | | | | | | | DEATH? |
| DID TOBACCO USE CONT | RIBUTE TO CAUSE O | OF DEATH YES | □ NO □ | UNCERTAIN | NX | | | · | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE OF DEATH (| Check only one) | | | | | | |
| 1 YES 2 NO | HOSPITAL: | | THER: Nursing Hore | e 5 🗆 Reeldence | 8 🗆 Other | r (Specify) | | | |
| 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJ | | 28d. DE\$ | CRIBE HOW IN | JURY OCCUR | iD O | |
| 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | |
| 3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number of Rural Route Numbe | | | a Number, | | | | | | |
| 29e. CERTIFIER (Check only (Ch | | | | | | | | | |
| (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) and menner as stated. | | | | | | | | | |
| | | | | | | | | | |
| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your) AS -24023 LI - 34-421 February 10, 1996 | | | | | | | | | |
| 10. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| AMEN. HE TERMO, SIMAT HOSPITAL | | | | | | | | | |
| 31. DATE FILED (Month Day, Ye 1996 | 92 REGISTRAR'S SIG | | | | | | | | |
| LED TO 1998 | () | | | | | | | | |

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WILBERT HORNER FEBRUARY 11, 1996 3:00PM /Medical 4s. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner TOWSON GREATER BALTIMORE MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9/22/14 Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 6. Sax **Funeral** 1⊠M 2□ F Deys Hours Yrs. 215-09-6278 Director 81 Usuel Residence of Decedent the Maryland 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic avent, the Medical Examiner must be notified at 1 Yas 2 No Director MARYLAND BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with I Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or it any injury or other traumatic event, the Magical Exemples must be any injury or other traumatic event, the Magical Exemples must be any 1710 RED OAK ROAD 21234 USA 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Datas: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th GRADE MANAGER BOWLING ALLEY 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) HENRY HORNER MABEL VIOLA DEBAUFRE 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) DORIS HORNER 1710 RED OAK ROAD PARKVILLE, MD 21234 20b. Piece of Disposition (Nema of cemalery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 2/14/96 COCKEYSVILLE, MD 4 ☐ Donstion 5 ☐ Other (Specify) DULANEY VALLEY MEM. GAR. 21. Signeture of Funerel Sarvice Licenses 22. Name end Address of Fecility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part1. Enter the diseasa, or complications the cause of the death shock, or heert feiture. List only one ceuse on each life. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disaese or condition resulting in deeth) Examiner physician and s the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Records, P.O. Box 68760, Physician/Medical Due to (or es e consaquance of): signed by the attending d be detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Rolymyoutes Crest Syndrome 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an eutopay periomed? Completed 2 14 No 1 Yes 200 No Division of Vital 25. Was case referred to medical Be 28. Place of Deeth (Check only one) examiner? 1 Yes, 2 No Other: 4 Nursing Home 5 Reaidence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury st Work? 28d. Describe how Injury occurred Certification: 5 Pending Investigation 1 Neturel 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29e. Certifier Medical 29d. Data signed (Month, Dsy, Year) 29b. Signature and title of cartifier 29c. Licensa number D16189 Karkar no 2-12-1986 30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print)

GEORGEN, KARKAR MOPA, 6565 N Charles St. Suite 668

TOUSSON MO 21204 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year)

Registrar

FEB 1 5 1996

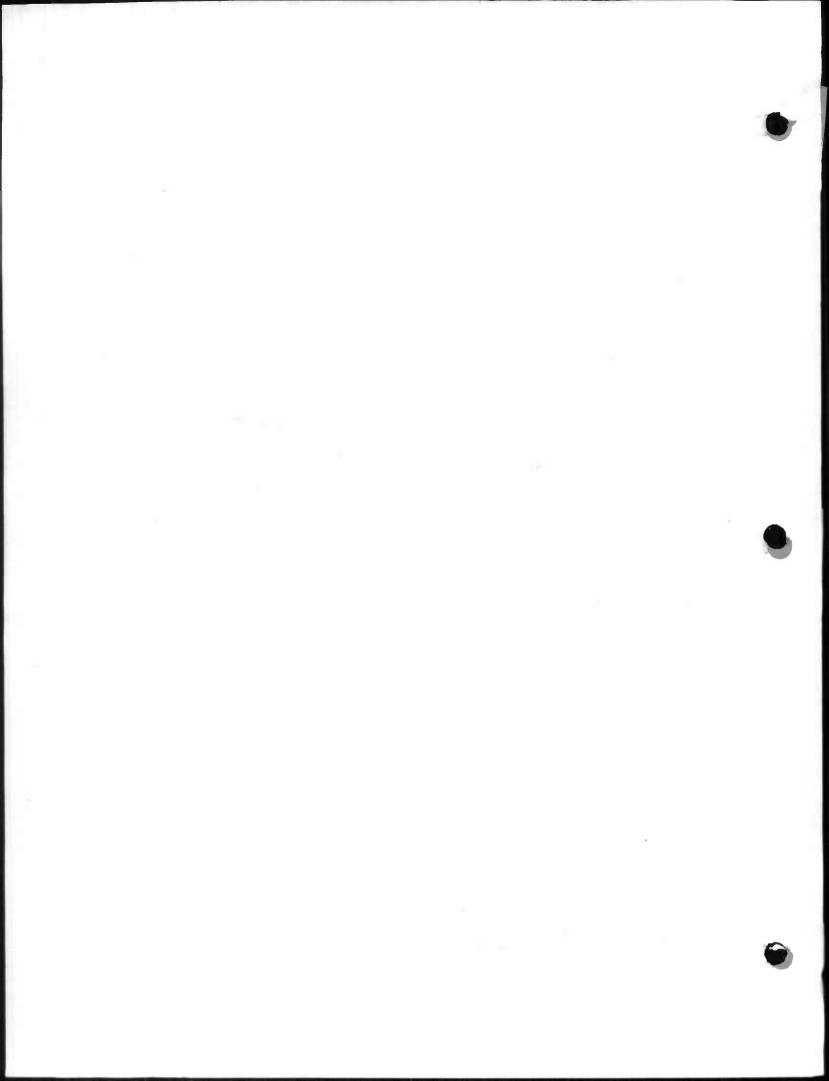
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DIVISION OF VITAL RECORDS, P.O. BOX 6876

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| | 1 - STATE OF MARYLAND / DEPARTMI CERTIFICA | ENT OF HEALTH AND MATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Leat) | TP | 2. DATE OF DEATH MONTH DAY L | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF U | NOER I YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH 8. | 96 9.55 P M BIRTHPLACE (State or Foreign | | | |
| | 219-52-7259 1 €M2 □ F 45 YRS. MONT | HS DAYS HOURS MIN. | June 15 1950 | MARYLAND | | | |
| 6 | | CITY, TOWN OR LOCATION OF DE | ATH 9c. COUNTY | | | | |
| OT | BON SECURS HOSPITAL BALTIMORE BALTIMORE | | | | | | |
| DIRECTOR | 1./4 | NN OR LOCATION BALTIMORE | E CITY | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| FUNERAL | | | | | | | |
| NE | 44 S, CATHERING STREET 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPAN | 223 U. | SA | | | |
| | 1 Never Merried 2 Merried FORCES? 1 YES 2 WNO | If yes, specify Cuben, Mexicar 1 YES 2 NO Specify | n, Puerto Ricen, etc.) | Black, White, etc. | | | |
| р ву | 3 Wildowed 4 Divorced | // | | BLACK | | | |
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| MP | | TCHER | | ORE | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) JOHN JOSEPH HILL SR. | ANNI | ME (First, Middle, Malden Surneme) E PERI | KINS | | | |
| 2 | 1 | | Route Number, City or Town, Stete, Zip Co | | | | |
| 20 20 20 20 20 20 20 20 20 20 20 20 20 2 | 20s. METHOD OF DISPOSITION 1 Surial 2 Cremetion 3 Removal from State pegalegy, cremetory or other pi | lecal A | DATE 200. LOCATION - CH | | | | |
| | 4 □ Donation S □ Other (Specify) WESTERN | STAK CEMETER | 1/2-13-96 CATONE | SVILLE, MO. | | | |
| CASI | JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | | | | |
| ERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory street, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST Approximate interval Between Onset and Death DUE TO (OR AS A CONSEQUENCE OF): CASTRO INTERVAL BLEED IN G DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | |
| | PAST II Other significant conditions contributing to death but not regulding in the | a underfulne eauer alum la | Post 1 Dec. 100 Au Augment | I an uses desired | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALWUTPLITION 24a. WAS AN AUTOPSY FINDINGS ANALIZED FRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO | | | | | | |
| AN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [28. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (C) | | V L I | | | | |
| SICIAN | EXAMINER? HOSPITAL: OT | HER: Nursing Home 5 - Residence | 6 Other (Specify) | | | | |
| PHYS | 27. MANNER OF DEATH 286. DATE OF INJURY (Month, Dey, Year) 286. TIME OF INJURY INJURY | 28c, INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRIBE HDW INJURY OCCUP | RED | | | |
| Ze is markeu, TED BY PH | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 26e. PLACE OF INJURY — At home, ferm, street building, etc. (Specify) | | 281, LOCATION (Street and Number or City or Town, State) | Rural Route Number, | | | |
| BE COMPLE | Suicide 4 Homicide 4 Homicide 4 Homicide 29a. CERTIFIER (Check only 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(e) and manner as stated. | | | | | | |
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| TO BE | Roscliffe de Thomason | 142 | -683 PF | ieb 8th 1996 | | | |
| | 2 ADCLIFFE _M. THOMAS 2000 WEST BACTIMORE St, MD. 21223 | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | |
| | FEB 1 5 1996 Jahr de de la faction la la la la la la la la la la la la la | | | | | | |

DHMH-16 Rev 1/89



Division of Vital Records, P.O. or Attending Physician: funeral director After this after death. within 24 hours after death To the Funeral Director: Hospital

Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred 5 Panding investigation Naturai 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Plece of tnjury - At home, term, street, factory, office building, atc. (Specify) 4 - Homlcide to Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. 29a. Certifier

(Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year)

9 37200 lance

30. Name and eddress of person who completed cause ot deeth (Item 23e) (Type, Print)

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Certification:

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State of Maryland / Department of Health and Mental Hygiene 96

| | | | | | | Ce | rtificate | e of | Death | | Re | g. No. | | - 0 | |
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| | Physic /Medi | | Solomon | | | | Ikin | | | | | LO, 19 | 996 | 2: | 45 PM |
| 3 | Exami | | 4a. Fecility Name (If not institution, git | ber) | | | | 4b. City, To | wn, or Lo | ocation of Death | 4c. Cou | nty of Death | | | |
| | | | 3717 Brentford Re | oad | | | | | Randa | llst | own | Ba | altimo | re | |
| | Funeral Director | | 214-24-2480 | Sex 12 M 2□F | 7. Aga (In yrs. lest) 70 | birthdey) Yrs. | If Undar Months | 1 Yaar Days | | 24 Hrs. Min. | 8. Date of Birth (Month, Dey, Year) Sept 4, 1925 9. Birthplece (Sountry) Maryla | | | | |
| | Dug | | Usuei Residence of Decedent 10a. Stete 10b. County | | 10c. City, To | own or Lo | ocation | | | | | | | 10d Inci | da City Limits |
| | he Maryi Se-f eho | Director | MD Baltim | ore | | | llstov | | | | | | | 1 🖰 | Yas 2 No |
| | 23a or 2 | rai Dir | 3717 Brentford | Road | | | 10f. Zip Code 10g, Citizen of Whet 21133 U.S. | | | | | | of What Cou U.S.A. | 1 | |
| 020 | be filed within 72 hours efter death with the Maryland nai Hyglene. Id other than "natural", or items 23a or 28e-f show event, the Medical Exeminer must be notified at | by Funerai | 11. Marital Status 1 Nevar Married 2 Married XXWidowed 4 Divorced | Armed For | 2 □ No | | Was Daceda If Yas, speci 1 ☐ Yes 2 | ity Cub | an, Mexican | gin? (Spi i, Puerto | ecity Yes or No- Rican, etc.) | 14. Race - Amarican indian, Black, White, etc. Specify: White | | | an, |
| 5-0 | 72 ho | it e | 15. Decedent's E | ducetion | | Sa. Dece | dant's Usuei | Occup | oetlon during most | t of work | ina 1 | 6b. Kind o | f Business/Ir | ndustry | |
| Maryland 21215-0020 | e filed within all Hygiene. Other than "r | Completed | (Specify only highest gr. Elementery/Secondery (0-12) 12 | College (1- | 4or 5+) | lifa. | kind of work DO NOT use Manac | | d) mosi | OF WORK | ing | | Sales | | |
| pu | e filed al Hygi other vent, ii | 0 | 17. Fethar's Nama (First, Middle, Last | ") | | | | | 18. Mothe | r's Name | e (First, Middla, N | faiden Sun | name) | | |
| /lai | should be and Mental I | To B | Samuel | | Ikin | | | | | Ye | etta | | Ka | plar | 1 |
| lan | A | | 19a. tntoment's Neme/Reletionship | (Type, Print) | 1: | 9b. Mailir | ng Addrass | (Street | end Numbe | er or Rur | el Routa Number, | City or To | wn, Stete, Zij | p Coda) | |
| ≥, ≤ | of Health Item 27 if | | Susan Krouss (1 | Daughter | | | | | ville | Rd, | Reisters | stown | , MD 2 | 1136 | 5 |
| Baltimore, | Pages 1 and neut of He int. If item | | 20e. Method of Disposition 1 | | teta ceme | tery, crer | sition (Nem metory or oti ce Heb | her pia | | 2-1: | Dete 2 2-1996 | | on-City or T sterst | | |
| Balt | permit. Page Department of Important: If i any injury or once. | | 21. Signature of Figheral Service Lice | Cata | 4 | | | Sol | Levin | son | & Bros. | | | 3035 | |
| Ò | Physician /Medical Examiner | | 23a. Pert1. Enter the disease, or comshock, or heart tellure. List only Immedieta Ceuse (Finel disease or condition resulting in deeth) | . Acu | te Myre | o not ent | dia | ot dyi | face | cerdiec o | or respiretory erre | st, | | Appro- Interva Onset | cimate al Between and Death |
| Box 68760, | eath certificate be executed attending physician and for use as the buriel-transit | Dua to (or as a consequence of): Atherosclerotic Coronary Heart Due to (or es e consaquence of): Due to (or es e consaquence of): Cause (Disase or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of): | | | | | | | | | Heart | Dise | rse | 10 | years |
| | 0 0 % | sicis | Pert II. Other significant conditions of | contributing to dea | ath but not resulting | In the u | nderfylng ca | use giv | ven in Pert I. | | 23b. Did tol | bacco use | contribute t | o the ca | use of death? |
| , P.O. | requires that the death cert een signed by the attendin hould be detached for use | by Physician | Hyperchole. | sterole | mia | | | | | | 1 🗆 Ye | 8 2 XN | o 3 Pro | bably | 4 Unknown |
| Division of Vital Records, | requir seen s should | Completed t | 1 | | | | | | | | 24e. Wes ar | | av | eldalie (| opsy tindings prior to n of cause |
| 9 | The | 5 | | | | | | | | | 1□ Ye | s 2 18 No | 1 | ☐ Yes | 2 No |
| /ita | od diffic | Be | 25. Was case refarred to medical examinar? | | | | | | | of Death | h (Check only one | 9) | 1. | | |
| 0 | Physician: The ribis equificate had director, page | ို | 1 Yes 2 No | | petient 2 ER/0 | | | _ | 4LI NU | | me 5 Resida | | | fy) | |
| sion | Attending P or death. ector: After by the funer | cation | 27. Menner of Death 12 Neturei 5 Pending investigatio | n | Day Year) | . Time of Injury | М 28 | Bc. injui Wo | ryat rk? Yes 2 □ l | | 28d. Dascribe ho | w injury oc | curred | | |
| DIX | tal or Attenders as Sirector; al Director; led in by the | Certification: | 3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicida determined | Zoe. Flace C | of Injury - At homa, g, etc. (Specify) | ferm, str | eet, tectory, | office | | | 28t. Location (Str City or Town, | | m <i>ber or Rur</i> | al Route | Number, |
| | To the Hospital or Attending Physicians within 24 hours after death. To the Funeral Director: After this sertific completely filled in by the funeral director. | edicai | 29a. Cartifier 1 Certifying Ph (Check only one) 2 Medical Exam | nyalctan: To the b niner: On the bas end menns | pest of my knowled sis of examinetion a ar stated. | ge, death and/or inv | occurred a vastigation, i | t the til | me, date end opinion, deat | d piece, o | end due to tha ca red at the tima, de | usa(s) and te and pled | menner as s e, and dua t | stated. to tha ca | usa(s) |
| | To t To t | Σ | 29b. Signature end title of certifier | x 1-1 | 1 | | 290. | - | se number | | 29 | | ned (Month, | | |
| | 6 | | 30. Name and address of puon who | completed cause | of death (Itam 23s |) (Type | Print) | | 0033 | | | | | | 1996 |
| | N | | | inters | M: [[| - | 29 | (| Dwin | 20 | Mills | Mo | 121 | 11- | 7 |
| | Sta | ite | 31. Dete filed (Month, Dey, Year) | | gistraris Signature | * | | | | 0 | | | | | |

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

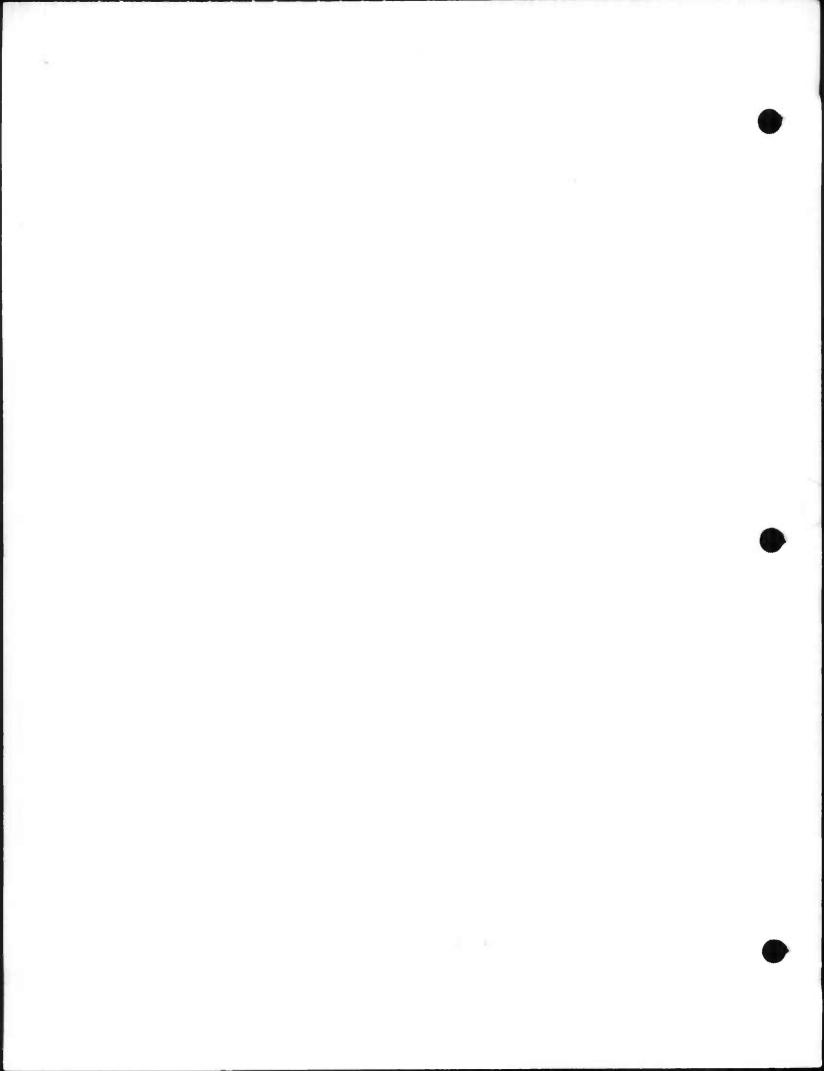
CERTIFICATE OF DEATH

REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | | | |
|---|--|--|--|---------------------------------|------------------|-----------------------------|----------------------|----------------------|--------------|---|---------------------|-------------------|-------------------------------------|--|
| | JOHN | HENRY | JAWORSK1 | Jr. | | | | | | | AY 1.0 | 96 | 2:20 a. M | |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER | 1 YEAR | IF UNDER | R 24 HRS. | 7. DATE OF BIRTH | 17 | | LACE (State or Foreign | |
| | 216-28-2560 | | 1 📉 M 2 🗆 F | 65 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) | 1021 | Country |) | |
| | 9a. FACILITY NAME (If not in | stitution, give str | reet and number) | 0 | | 9b. CITY | TOWN (| OR LOCATI | ON OF DE | | | NTY OF DE | imore, MD. | |
| œ | Fort Howard | | | onton | | | | | | AID | | altin | | |
| 읝 | RESIDENCE OF DEC | | cuccuc C | incer | | Ft. Howard Bal | | | | | | alli | ione. | |
| DIRECTOR | 10a. STATE | 10b. COUNTY | | | 10c. CIT | 10c. CITY, TOWN OR LOCATION | | | | | | T | 10d. INSIDE CITY | |
| | Maryland | Bali | timore | | | Bradshaw | | | | | | | LIMITS? | |
| AL | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | | | 10g. CITIZEN OF WHA | | | |
| FUNERAL | 8128 Brad | shaw Ro | oad | | | | | | 2102 | 1 | | U.S. | Α. | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | 13. \ | WAS DEC | CENDENT (| OF HISPAN | IC ORIGIN? (Specify Ye | or No- | 14. RACE | - American Indian, | |
| BY F | 1 X Never Married 2 3 Widowed 4 Divo | | FORCES? 1 IF YES, GIVE W | AR OR DATES | NO | | | 2 NO | | , Puerto Rican, etc.) | | Black, | White, etc. | |
| | J Widowed 4 Divo | rced | Korean (| Conflic | ct | - 1 | | | ,, | | | ораслу | White | |
| COMPLETED | 15, DEC (Specify only | highest grade of | ATION completed) | 16a. | DECEDENT'S | USUAL OC | CUPATIO | ON pet of working | na | 16b. KIND OF BU | SINESS/IN | DUSTRY | | |
| <u> </u> | Elementary/Secondary (0 | | College (1-4 or 5 + | -> | life. Do NOT u | se retired.) | anny mo | or works | w | | | | | |
| ₩ P | 12th grade | | | | Barte | nder | | | | Tav | ern | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Angeline Shuth | | | | | | | | | | | | | |
| BE | | | | | | | | | | ne Skurk | | | | |
| 0 | 199. INFORMANT'S NAME (TyperPrint) (brother) Ferdinand F. Jaworski 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8128 Bradshaw Road Bradshaw MD 21021 | | | | | | | | | | | | | |
| | The state of the s | | | | | | | | | | | | | |
| | 20e_METHOD OF DISPOSITION 20b_PLACE AND DATE OF DISPOSITION //Name of DATE 20c_LOCATION — City or Town State | | | | | | | | | | | | n, Slata | |
| | 4 Donation 5 Dotter (Specify) St. Stephen's Church Cem. 2/17 Bradshaw, Maryland | | | | | | | | | | | | ryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. | | | | | | | | | | | | | |
| 9705 Belair Rd., Baltimore, | | | | | | | | | | MD 2 | 1236 | | | |
| 23 PAUL I Enter the diseases or completions that assess that assess that the death December 1 | | | | | | | | | | | Approximata | | | |
| | iMMEDIATE CAUSE (Fin | ert Isliure. L | lst Dnly Dne ceu | se Dn eech I | ine. | | | | 7. | | | | Interval Batween Onset and Death | |
| | diseese or condition | 91 | Res | nirato | res Arra | root | | | | | | | Onset and Dastin | |
| | resulting in death) | | Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| z | | | | | | | r | | | | | | | |
| CERTIFICATION | Sequentially list condition if any, leading to immediate | | DUE TO | anced OR AS A CON | SEQUENCE O | F): | | | | | | | + | |
| 3 | cause. Enter UNDERLY!! CAUSE (Disease or Injur | NG | | | | | | | | | | | | |
| E | that initiated events | · • | DUE TO | OR AS A CON | SEQUENCE O | F): | | | | | | | | |
| E | resulting in death) LAST | d | | | | | | | | | | | | |
| 9 | PART II. Other algnificer | nt conditions | contributing to | death but no | t requiting | In the un | declules | | elica la l | Part I. 24s. WAS AN | | | | |
| MEDICAL | | | | | A rounding | iii tile oli | aci iyii i | A conse (| Jiveii iii i | PERFOR | | 1 | WERE AUTOPSY FINDINGS | |
| | | | | | | | | | | t _ YES 2 | M NO | | COMPLETION OF CAUSE OF DEATH? | |
| - 1 | DID TORACCO H | CE CONITE | IDLITE TO CAL | USE OF D | PARIL NO | | | | | | | 1 | ☐ YES 2 💢 NO | |
| A | DID TOBACCO US | | IBUIE IO CA | | ACE OF DEA | | _ | JUNC | ERTAIN | 1 124 | | | | |
| PHYSICIAN: | EXAMINER? | | HOSPITAL: | | | OTHER | : | _ | | | | | | |
| ¥∥ | 27. MANNER OF DEATH | | 1 N Inpetient 2 28a, DATE OF | | | | ing Hom | | sidence (| Other (Specify) | | | | |
| | 30 | Pending | (Month, Da | | 28b. TIM | URY | WO | RK? | 7 | 28d. DEŞCRIBE HOW I | NJURY OC | CURED | | |
| B | racidatin | nvestigation | 28a PLACE OF | IM HIDV A | home laws | | | rES 2 | NO | | | | | |
| 8 | | 3 Suicida 6 Could not be building, etc. (Specify) 281. LOCATION (Street and Number or Rural Inches) 282. PLACE OF INJURY — At home, lerm, streat, lactory, office building, etc. (Specify) | | | | | | | | | | or Rural Ro | ute Number, | |
| | | | | | | | | | | | | | | |
| 1 11 | 20a CERTIFIER | etermined | | | | | | | | | | | | |
| MP. | 29a. CERTIFIER (Check only one) | FYING PHYSIC | IAN: To the best of | my knowledge, | death occurre | ed at the tir | ne, data | and place. | end due t | o the cause(a) and mer | nor sa stat | ed. | | |
| COMPL | (Check only | FYING PHYSIC | IAN: To the beat of ax | my knowledge, amination end/ | death occurre | ed at the tir | ne, data Hnion, d | and place | , end due t | to the cause(a) and mer time, data and placa, an | nner as stat | ed. e cause(a) | and manner as stated. | |
| 3E COMPLET | (Check only | FYING PHYSIC | IAN: To the best of a | my knowledge, amination end/ | death occurre | ed at the tir | ne, data Hnlon, d | eath occur | end due to | ime, data and place, an | d due lo th | e cause(a) | and manner as stated. | |
| H H | (Check only 2 MEDIC 29b. SIGNATURE AND TITLE | FYING PHYSIC CAL EXAMINER OF CERTIFIER | on the beats of ax | amination end/ | or investigation | en, In my op | ne, data | eath occur | red at the t | ime, data and place, an | d due lo th | e cause(a) | | |
| | (Check only 2 MEDIC 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF | FYING PHYSICI CAL EXAMINER OF CERTIFIER PERSON WHO | COMPLETED CAUS | M - | TEM 27) (Type, | Print) | einion, d | 29c. LICE | ENSE NUM | ime, data and placa, an | 29d. DAT | E SIGNED (F | Month, Day, Year) | |
| H H | (Check only 2 MEDIC ONE) 20 MEDIC ONE) 29b. SIGNATURE AND TITLE TO LONG ON A MEDIC ON A | FYING PHYSICE CAL EXAMINER OF CERTIFIER PERSON WHO FAHED | COMPLETED CAUS | E OF DEATH (I | TEM 27) (Type, | Print) | einion, d | 29c. LICE | ENSE NUM | ime, data and placa, an | 29d. DAT | E SIGNED (F | Month, Day, Year) | |
| 띪 | (Check only 2 MEDIC 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF | FYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO FAHED | COMPLETED CAUS M. D. 9 | E OF DEATH (I | TEM 27) (Type, | Print) | einion, d | 29c. LICE | ENSE NUM | ime, data and place, an | 29d. DAT | E SIGNED (F | Month, Day, Year) | |

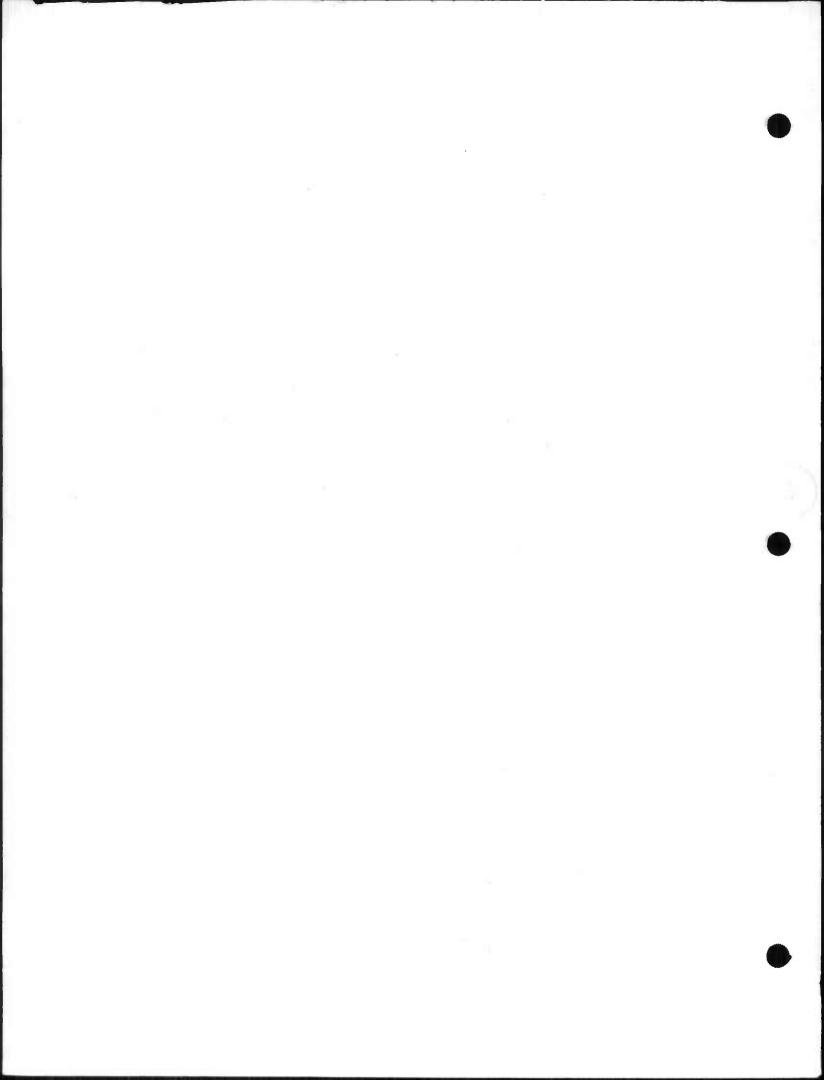
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| | 1 - FOR STATE REGISTRAR | ATE OF MARYLAND | / DEPARTME | | | MENTAL | HYGIENE REG. NO. | | | |
|--|---|--|------------------------|-----------------|--------------------------------------|---------------|-------------------------------------|------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | JEATH | 2. DATE O | E DEATN | 3. TIME OF DEATN | | |
| | Constance M. John | ison | | | | Febru | iary 1 | 3, 1996 | 10:25 A. M | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 111111111111111111111111111111111111111 | lest birthday) # UN | DER 1 YEAR | IF UNDER 24 HRS. | 7 DATE OF | E DIOTH | 0.0 | IRTHPLACE (State or Foreign | |
| | 213-20-6007 1 □ 9a. FACILITY NAME (If not institution, give street and | M 2 (X) F 70 | YRS. | | R LOCATION OF DE | | 27,19 | 9c. COUNTY | aryland | |
| OR | 4322 E. Joppa Road | (turnos) | .96. 0 | | timore | AIH | | Balti | | |
| 2 | 10a. STATE 10b. COUNTY | | 10c. CITY, TOW | N OR LOCATI | ON | <u> </u> | tod. INSIDE C | | | |
| FUNERAL DIRECTOR | Maryland Balt | timore | | | ltimore | | | 1 TYES 2 NO | | |
| RA | 4322 E. Joppa Road | | | 10f. | 21236 | | | | OF WHAT COUNTRY? | |
| 3 | 11. MARITAL STATUS 12. W | AS DECEDENT EVER IN U.S. | ARMED | 13. WAS DECE | ENDENT OF NISPAN | IIC ORIGIN? | (Specify Yea o | | RACE — American Indian, | |
| BY FI | 1 Never Married 2 Y Married FC | PRCES? 1 TYES 2 YES, OIVE WAR OR DATES | (NO | If yes, spe | cify Cuban, Maxica 2 X NO Specify | n, Puarlo Ric | | | Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/IN | | | | | | | | NESS/INDUSTI | | |
| | | | | | | | | T (| | |
| 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | ient co. | |
| | | | | | | | | | | |
| | | | | | | | | | (a) | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. | | | | | | | | | | |
| | 1/1/10 DE THI | Baltim | | | | | | | | |
| CERTIFICATION | 23. PART I. Enter the diseases, for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | DART II Other classificant and distance and | the state of the s | | | | - I | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significent conditions conf | ributing to deeth but no | t resulting in the | underlying | cause given in | | 24a. WAS AN A PERFORM t YES 2 | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| Σ. | DID TOBACCO USE CONTRIBUT | E TO CAUSE OF DE | ATH YES |] NO E | UNCERTAIL | NO | | - | 1 YES 2 NO | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 28. PL | ACE DF DEATH (Ch | | | | | | | |
| YSI | 1 U YES 2 NO 1 0 | npatient 2 - ER/Outpatient | 3 🗆 DOA 4 🗆 | | Rasidence | 6 🗆 Other | (Specify) | | | |
| | t Netural 5 Pending | 28a. DATE DF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | | URY AT RK? 'ES 2 NO | 28d. DE\$0 | CRIBE NOW IN | JURY OCCURE | ED | |
| ED BY | 2 Accident | 28a. PLACE OF INJURY — At building, etc. (Specify) | home, farm, street, | lactory, office | | | TION (Street an r Town, State) | nd Number or R | tural Route Number, | |
| 29s. CERTIFIER (Check only (C | | | | | | | | | | |
| COMPLET | (Check only one) 2 MEDICAL EXAMINER: On t | | | | | | | | use(a) and menner as stated. | |
| BE C | 29b. SIGNATURE AND TITLE OF CENTIFIER | ~ | | | 29c. LICENSE NUI | | | 29d. DATE SIG | GNED (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WNO COM | DI ETED CAUSE OF DEATH I | TEM 27: /5 0::: | | D226 | | | 0- | 17/6 | |
| | EBRAHIM I | AR CHI | TEM 27) (Type, Print) | | osu | n. | DR | 100 | BAUTMUS | |
| | 31. DATE FILED (Month, Day, Year) | 2. REGISTRAR'S SIGNATURE | E | | | | | | 11201 | |



Item1 2-15-96 FilmG732 W.H.Per F/H Pleas

| e Type or Print In Black Indelible Ink. Assure State of Maryland / Department of Health an Certificate of Death | tate of Maryland / Department of Health and Mental Hygiene | | | |
|---|--|--------------|----------------|--|
| | Reg. No. | | | |
| Blanche Elizabeth Jankiewicz | 2. Data of Death Month Day | Year 1006 | 3. Time of Dea | |

Funeral

Director with the Maryland r 28a-f show a notified at

7 is marked other than "natural", or items 23a or traumatic avent, the Medical Examiner must be r permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 28a and Injury or other traumatic avent, tra Medical Examera-

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the burial-transit Division of the Records, P.O. Box 68760, 950 ò peed 108 page 2

this funeral e Hospital or Attending 124 hours after death. e Funeral Director: After I To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: All completely filled in by the fu

1. Decedent's Nama (First, Middla, **Physician** BLANCHE E JANKIEWICZ 1996 03:05 P.M. /Medical LFR. 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. Birthpiaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1 M 2 M F Yrs. 215-16-9468 JULY 6, 1921 MARYLAND Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 121 NORTH BEND TERRACE 21060 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 🛣 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No þ Specify: 3XXWidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 SUBSTITUTE TEACHER A.A. CO. PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumama) FREDERICK STERGER ANNA HUETTNER 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) JOANNA K. HELDRETH 121 NORTH BEND TERRACE, GLEN BURNIE, MD 21060 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Dother (Specify) GLEN HAVEN MEMORIAL PARK 2/14/96 GLEN BURNIE, MARYLAND 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME 21. Signature of Funaral Sarvice Ocansee 1 SECOND AVENUE S.W., GLEN BURNIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death myecalid inforted Immediate Cause [Cinal] disaasa or condition rasulting in daath) Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cerebro voscular þ Contrac any Home 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 No 25. Was casa rafarred to medical exeminer? Be 26. Piaca of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 9 1 Yas 20 No 28a. Data of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 2 Accident invastigation 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide edical 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and dua to the causa(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and fifte of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 023624 30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print) BASANT K. KHANUL. 31. Data filed (Month, Dey, Year) 6 FFR 1 5 1996

KHANDELWAL, M.D. 1600 CRAIN HIGHWAY, SW, GLEN BURNIE, MARYLAND 21061

State Registrar

The state of the s T IC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** 10 HERMINA LIA FEBRUARY 13 1996 40PM /Medical 4a. Facility Neme (If not institution, give street and number 4b. City, Town, or Location of Deeth-4c. County of Deeth Examiner ST. AGNES HOSPITAL BALTIMORE BALTIMORE CITY If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Deys 1 M 2 DXF 88 Yrs 215-42-0351 MARYLAND FEB. 26,1907 Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 MAIDEN CHOICE LANE - PV-404 21228 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 🛣 No Specify: WHITE þ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 9TH GRADE HOMEMAKER HOMEMAKING 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be ALFRED E. HORNIG MARIE E. GOHLINGHORST 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROBERT KLENNER 610 MOJABE TRAIL - MAITLAND, FLORIDA 32751 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) LOUDON PARK CEMETERY 2/17 BALTIMORE 21. Signeture of Funerel Service Licensee 22. Neme and Address of Feeility HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 MI 23a. Peht_Enter the disease, or complications that caused the day. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediete Ceusa (Finei dAys diseese or condition rasulting in deeth) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were sutopsy findings available prior to completion of cause of death? 24e. Wes an autopay performed? Completed 1 Yes 2 1010 1 Yes 2 No Be 25. Wes case referred to medical 28. Place of Deeth (Check only one) examiner? Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 \npatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion

physician and s the burial-transit The law requires that the death certificate be executed of Vital Records, P.O. Box 68760, attanding ō thed signed by the been si has pa 2 paga certificata Physician: director, After JIVISION To the Hospital within 24 hours
To the Funeral Complately filled

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Modical Examinal must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once.

Physician /Medical

Examiner

filed within 72 hours after death with I Hygiena.

Baltimore, Maryland 21215-0020

the Manyland

2 Accident 3 Suicide

4 Homicide

(Check only one)

29e, Certifier

6 Could not be determined

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, and due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at tha time, data end placa, end due to the cause(s) end manner steted. 29c. License number 29d. Dete signed (Month, Day, Year)

29b. Signeture and title of cartifier

5 1996

MBOUDOY, MD 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

SIMON MBOURN ST Across 1tx8, mf goo Coson Are Baltime, mo 21209

31. Date filed (Month, Day, Year) State Registrar

Medical

32. Registrer's Signeture

96-0687-005

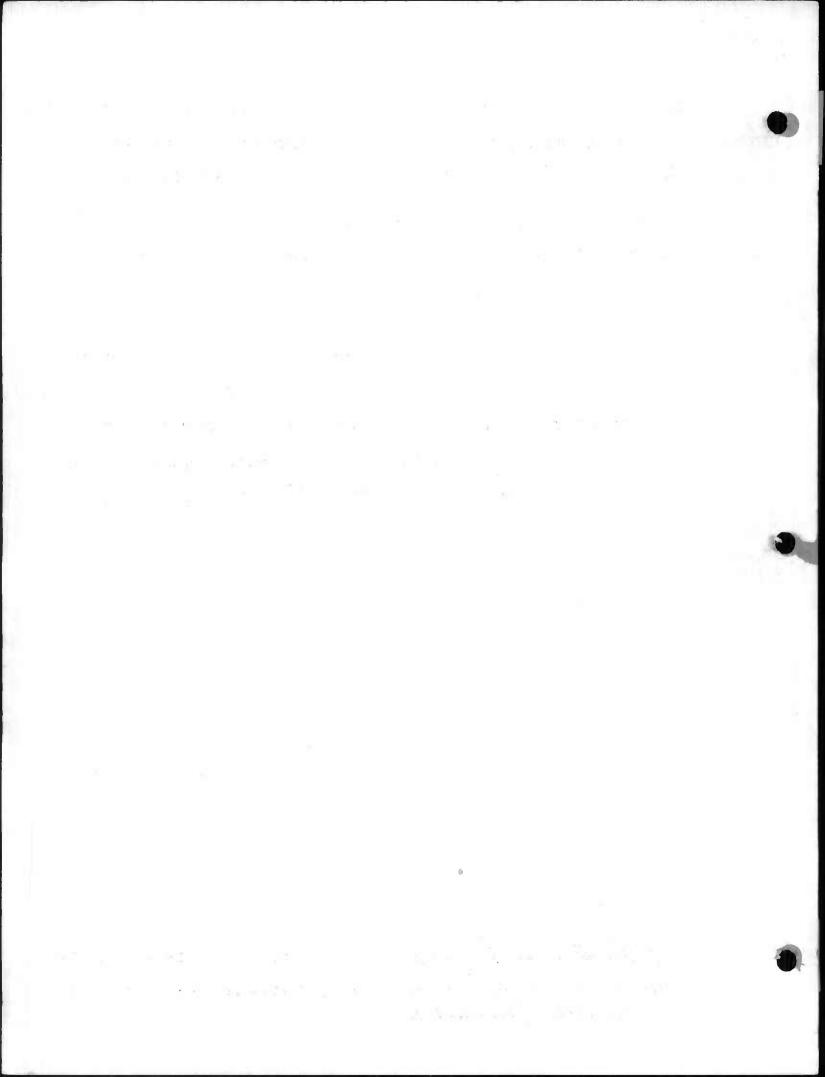
Item4b 2-15-96 FilmG732 W.H.Per F/H
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible,

ITEMS: 23 PART I, 27, 28a-f, State of Maryland / Department of Health and Mental Hygiene

| CIP PE | R M | : 23 PART I, 27, 28a-f EO FILM G-733 3/4/96 t | t | | Certificat | | | | Reg. No. | 96 | | 0 3 3 0 |
|--|--------------------------|---|---|------------------------------|--------------------------------------|--------------------|--|--|---|------------------------------------|------------|---|
| Physic | olan | 1. Decedent's Neme (First, Middle, La | st) | | | | | 2. Date of Dea Month | | Yes | | Time of Death |
| /Med | | DONALD | | LLIAM | | | KATZ | FEBRU | ARY 1 | 2, | 1996 | 9:55AN |
| Exam | iner | 4e. Fecility Name (If not institution, give | | | | 4b. City, Town, or | | | unty of De | | | |
| Funana | | 202 CARAWAY RC 5. Social Security Number 6.5 | If Under 24 Hrs | | | _ | MORE | Ctate as Ensaign | | | | |
| Funera Director | | | 1 ⊠ M 2□ F | (In yrs. lest birth | Months | Days | | (Month, Day | (Month, Day, Year) | | | State or Foreign |
| death with the Maryland rms 23a or 28a-f show Enyest be notified at | Director | | BALTIMORE | 10c. City, Town | or Location | NWC | | | | | | side City Limits Yes 2 No |
| ath with the 23e or 2 west be m | rai Dire | 10e. Street and Number 202 CARAWAY RD., | APT. 2-D | | 10f. Zip | Code | 21136 | | | g. Citizen of What Country? USA | | |
| 020 uns after des al', or items | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ev Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: | , | 13. Wes Deced If Yes, spec | | Hispanic Origin? (S an, Mexican, Puer Specify: | Specify Yes or No- to Rican, etc.) | | Rece - Ar Biack, W ecify: | | |
| Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at mones. | r, the Medical Completed | 15. Decedent'a E (Specify only highest gra Elementery/Secondery (0-12) | ducation ade completed) Coilege (1-4or 5+) | | ife. DO NOT us | rk done | during most of wa | rking | WHITE 16b. Kind of Business/Industry NONE | | | |
| other vent, | Bec | 17. Fether's Name (First, Middle, Last, | | | 1,0 | J. 14 LJ | 18. Mother's Na | me (First, Middle, | Maiden Sui | meme) | IACIA | |
| ylai ylai went ment erice | 2 | GERALD | | KAT | rz | | | ESTHER | | | POSI | NER |
| Maryland d 2 should be file th and Mental Hy 7 Is marked othe traumatic event | | 19a. Informant's Name/Relationship (| | 19b. N | Mailing Address | (Stree | t and Number or R | ural Route Numbe | r, City or To | own, State | , Zip Code | ,) |
| Baltimore, I semit. Peges 1 and Peptrument of Health moortant: If item 27 my Injury or other tony Injury or other temperatures. | | MR. GERALD KATZ 20a. Method of Disposition 1 Dayrial 2 Cremation 3 C | Removal from State | 20b. Place of D cemetery, | isposition (Nan crematory or o | ne of ther pla | ca) | Date | VINGS MILLS, MD 21117 20c. Location - City or Town, State | | | itete |
| Baltim Pemit. Pe Department Important: any Injury | | 4 Donation 5 Other (Specify) CHIZUK AMUNO -ARLINGTON-2-14-1996- BAI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | | | | | | | | | | , MD |
| Physician /Medical Examiner | | 23e. Pert1. Enter the disease, or com ahock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) | a. COCAINE | E NARCOTI | t enter the mod | e of dyi | | c or respiratory and | est, | | Appr | roximate voxil Between et and Death |
| of Vital Records, P.O. Box 68760, Physician: The lew requires that the death cartificate be executed this certificate has been signed by the ettending physician and all director, page 2 should be detached for use as the buriel-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | c | ue to (or as a co | | | | | | | | |
| 1s, P.O. Box 6(res that the death certific, igned by the ettending pl be detached for use as it | by Physician/ | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did 1obecco use contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | cause of death? |
| f Vital Records, yelden: The lew requires th feerificate hes been signe director, page 2 should be o | Completed t | | | | | | | 24a. Was a perfor | | | available | on of cause |
| of Vital Inhysician: The this certificate all director, pag | Be | 25. Was case referred to medical exeminer? | 11 | | | | | eth (Check only or | те) | | // | |
| on of ding hys | on: To | 1X | Hoapital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y | | atient 3 DO | 8c. Inju | | fome 5XX Resid | | | pecify) | |
| isic death death ctor: | Certification: | 2 Accident 3 Suicide 4 Homicide | TOUND. Z-I | - At home, farm | | , office | Yes 2XXNo | UNKNOWN 28f. Location (S City or Tow OWINGS MI | | | _ | ROAD ^{er,} |
| Div To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b | edical | 29e. Certifier (Check only one) | ysician: To the best of r liner: On the basis of ex and manner state | camination &ad/c | eath occurred e or Investigation, | et the ti | me, dete end place opinion, death occu | and due to the c | ause(s) and | manner | as stated | ause(s) |
| To the within | M | 29b. Signeture and title of certifier 30. Name and address of person who | M. King | , eyo | | | c.M.E. | | 9d. Date si | | | (ear) 1996 |

State Registrar 31. Date filed (Month, Day, Year)
FEB 1 5 1996

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** LAWRENCE Month Yeer LEANDER FEB. 1996 13. 0955 AM /Medical 4e. Fecility Neme (If not institution, give street end number)
4612 HAMPNETT AVENUE 4b. City. Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 100 M 2□ F Deys 049-34-143 Yrs Director Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Expresse, must be notified at Director 1 Ves 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Stree ,5 ne Funeral permit. Peges 1 and 2 should be filed within 72 hours effer deat Department of Health end Mental Hyglene. Important: If Itam 27 is marked other than "natural" any injury or other traumatic events. 12. Wes Decedent Ever in U.S. Armed Forces?

1. Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1□ Yes 20 No þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 0 Elementary/Secondery (0-12) College (1-4or 5+) ineering 18. Mother's Nema (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) eande rence Mother fermant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number of Rural Route Number, City or Town, Enfield 06082 01 20e. Method of Disposition 20b. Piece of Disposition (Name of cometery, cremetory or other pla Dete 20c. Location - City or Town, State Burial 2 Cremetlon 3 Remove from Stete
4 Donetion 5 Other (Specify) ral Ville enetery 21. Signeture of Funeral Service Licenses 22 Name end Address of Facility Balto, ma 4300 wabash 21213 23e. Pert1. Enter the disease, or compilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner physician and s the buriel-transit law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) ettending p Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. After this certificate has been signed by the funeral director, page 2 should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? Partial 1 Yes 1 S Yes 2 □ No Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home XXResidence 6 Other (Specify) 2 XIXYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Te the Hospital or Attending Pt within 24 hours efter death.
To the Funeral Director: After th completely filled in by the funera 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

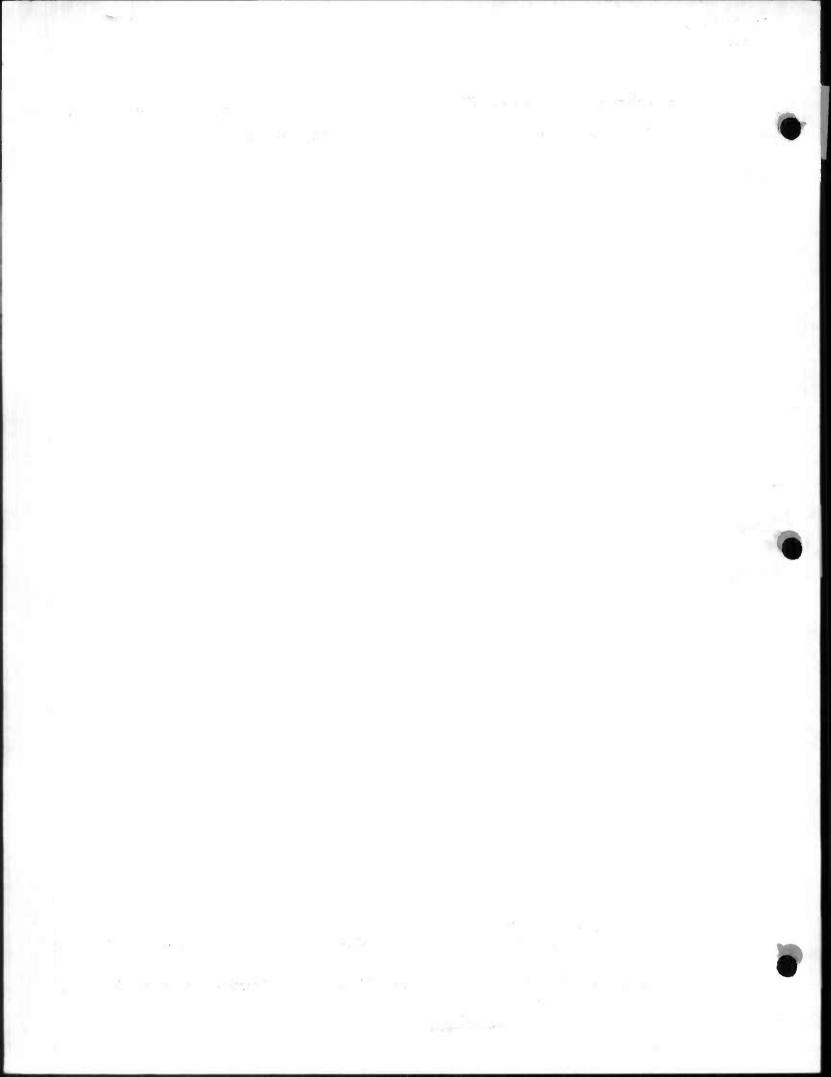
XX Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical 29b. Signeture and title of contifier 29c. License number 29d. Dete signed (Month, Dey, Year) O.C.M.E FEBRUARY 14, 1996 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DWId 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture FEB1 5 1996

Power



1996

3. TIME OF DEATN

11;47 P.

REG. NO.

2. DATE OF DEATH

February 13

| MALTIMORE, MARYLAND 21215-0020 | . OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 how une down Page 6 may be retained by the hospital or attending physici | |
|--|--|---|
| Ā | 1000 | |
| | 2 | 9 |
| | 2 | 4 |
| DIVISION OF VITAL RECORDS, P.O. BOX 6876 | ath certificate be executed with | |
| RECORDS, | requires that the de | |
| N OF VITAL | IG PHYSICIAN: The law | |
| OISINIC | OR ATTENDIN | |

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Lefko

| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YEAR | IF UNDER 24 | HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTNPLACE (State or Foreign Country) | |
|--|---------------|--|---|---|---------------|---------------------|-------------------|---------|--|-----------|---|--|
| P | | 215-01-1355 9e. FACILITY NAME (If not institution, give si | 1 M 2 X F | 98 | YRS. | | | | March 12, | | | |
| 3 should | Œ | | | | | 9b. CITY, TOWN | | OF DE | ATN | | NTY OF DEATN | |
| 22 | DIRECTOR | Meridian Perring | | | | Baltimore Co. | | | | | | |
| Sages | | 10e. STATE 10b. COUNTY | | | | Y, TOWN OR LOC | | | | | 10d. INSIDE CITY LIMITS? | |
| mit. | AL D | Maryland | N/ | Α | В | altimor | C1 | ty | | ton CIT | 1 X YES 2 NO | |
| sit pe | RA | 6225 York Road | Apt. 3 | 10 North | 1 | 1.0 | 21212 | | | 1117 | | |
| prysidea burial-transit permit, Pages 1, | FUNER | 11. MARITAL STATUS | United States NISPANIC ORIGIN? (Specify Yea or No. 14. RACE - American Indian, | | | | | | | | | |
| the buri | В | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | | MAR OR DATES | 10 | | S 2 X NO | | , Puerio Rican, etc.) | | Specify: White | |
| USe as | E COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | (G | ive kind of a | USUAL OCCUPAT | | | 16b, KIND OF BUS | INESS/INC | DUSTRY | |
| shed for | | Elementary/Secondary (0-12) | College (1-4 or 5 | +) /// // // // // // // // // // // // / | Ma: | sseuse | | | Heal | th Se | ervice | |
| rage or may be trained by the tooppea or assembling mini director, page 5 should be detached for use as the minier must be notified at once. | | 17. FATHER'S NAME (First, Middle, Last) Theodore Warholik Eva Stanczak | | | | | | | | | | |
| 5 should notified | FO B | 190. INFORMANT'S NAME (Type/Print) Alexander Lefko | | 100 | | | end Number or | Rural A | oute Number, City or Town | | | |
| page 5 | | 200, METHOD OF DISPOSITION | | | | X Z4033 | | 111101 | re, Marylan | ~~~ | Z14 City or Town, State | |
| rector, p | | 1 X Buriel 2 Cremetion 3 Rem 4 Donetion 6 Other (Specify) | oval from State | St. M | icha | el Ceme | tery | Feb | 1 | | ore,Maryland | |
| examiner | | 21. SIGNATURE OF FUNERAL SERVICE MICENSEE MILTON J Knight Jr Leonard J. Ruck Funeral Home, Inc. | | | | | | | | | | |
| | | Milton | Knig | IN I | | 530 | 5 Harf | ord | Rd. Balti | more | . Maryland 21214 | |
| or removal medical | | 23. PART I. Enter the diseases, of a shock, or heart fellure. | complications in List only one ca | et caused 1) e de use on each line | eth. Do i | not enter the m | oda of dying | g, such | as cardiac or reapi | ratory an | Interval Between | |
| he on | | IMMEDIATE CAUSE (Finel disease or condition | 5 | boch | un' | 1 | fra: | 1 | Pine | 100 | Onset and Death | |
| completely file ial, cremation, event, the | NO | resulting in death) | DUE TO | OPAS A CONSE | | F): | 100 | | l'se | | - Pray | |
| | | Sequentially list conditions, | b. DHE TO | (OR AS A CONSE | W | 1 | 1300 | e j |) | | year. | |
| sician and o prior to buria traumatic | CAT | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | |
| attending physician mal Hygiene prior to | CERTIFICATION | that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| the attending phy Mental Hygiene Ijury, or other | CER | d. | | | | | | | | | | |
| Me the | - 1 | PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part i. 246. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO | | | | | | | | | | |
| been signed by it. of Health and is shows any in | EDICAL | | | - | | | | | 1 □ YES 2 | 06 | COMPLETION OF CAUSE OF DEATH? | |
| of He | Σ | DID TOBACCO USE CONT | DIDLITE TO CA | ALICE OF DEA | TLI VI | S D NO I | T UNCE | DTAIL | 10 | | 1 TES 2 NO | |
| has Dep | IAN: | 25. WAS CASE REFERRED MEDICAL | KIBUTE TO CA | | | TH (Check only on | | KIAIIY | i ke | | | |
| Unicate h | SICI | EXAMINER? | HOSPITAL: | ☐ ER/Outpetlant 3 | DOA | OTHER: | ome 5 🗆 Rask | dence (| 8 Other (Specify) | | | |
| ther this certific eath with the S marked, or I | PHYSIC | 27. MANNER OF DEATH 1 Natural 5 Pending | 26e. DATE Of (Month, i | F INJURY Day, Year) | 26b. TIM | JURY V | NJURY AT VORK? | | 28d. DESCRIBE NOW I | NJURY OC | CCURED | |
| After II | ВУ | 2 Accident Investigation | 28s PLACE | OF INJURY — At ho | me ferm | | YES 2 1 | NO | 281 I OCATION (Street | and Mumba | or Rural Route Number, | |
| THE FUNERAL OR ATTENDINGS PRESIDENCE. IN THE FUNERAL OIRECTOR: After this certificate filled within 72 hours after death with the State PORTANT: If Item 28 is marked, or Item | ETED | 3 Suicide 6 Coule not be 4 Homicide determined | | , etc. (Specify) | mie, min, | arraer, rectory, on | ics | | City or Town, State) | ind Numbe | Y OF HURST PIOUSE NUMBER, | |
| RAL OIRECT 72 hours | COMPLET | onel — | | | | | | | to the cause(s) and man | | nted. the cause(s) and manner as stated. | |
| TO THE FUNERAL DE filed within 72 IMPORTANT: If | ш | 29b. SIGNATURE AND TITLE OF CERTIFIE | AT. | | | | 29c. LICEN | | | | TE SIONED (Month, Day, Your) | |
| TO THE De filed | TO B | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAL | | M 27) (Tuna | . Print) | 100 | 83 | RIF | 12 | 2/14/96 | |
| | | Gracito Patrici | o M.D. 8 | 903 Harf | ord | | timore | , 1 | Maryland | 2123 | 4 | |
| 4 | | FEB 1 5 1996 | Laurdso | A ALTON | | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

4.

Please Type or Print in Black indelible lnk. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

03996

| | | | | | | | | eniiicai | e oi | Death | 1 | | Reg. No | o | |
|--------|--|-------------|--|--------------------------------|------------------------------|-------------------------|-----------|-----------------------------|------|-------------------------|-----------------|--------------------------------------|---------|-----------|-----------------|
| | Physic /Medi | | 1. Decedent's Nar Adam | na (First, Middle, C . Mac) | | | | | | | | 2. Date of De Month Feb. | | y 19 | Year 96 |
| 1 | Exami | | 4a. Facility Nama (If not institution, give street and number) Meridian Nursing Home 4b. City, Town, or Loc Baltimor | | | | | | | | | | | | |
| | Funeral Director | | 5. Social Security 217-03 | | 6. Sex X [X]M 2□ F | 7. Age (In yrs. | Vro | Months | Day: | | 24 Hrs. Min. | 8. Data of Bir (Month, De Aug. | | | 9. Birth Cou |
| 5-0020 | with the Maryland a or 28a-f show be notified at | al Director | Usual Residence 10a. Stata MD | 10b. County | Arunde1 | | y, Town o | Location | MD | | | | | | |
| | th with the 23a or 28 at be not | | ai Direc | ai Direc | 10e. Street and No | umber 11ace i | | 10f. Zip | | 1225 | | 10g. Citizen of What Co | | | |
| | hours after death urel, or items 23 | by Funer | | rried 🏌 🂢 Marrie | Armed F | 2 X) X 0 | | | | | | |)- | | ck, Whita |
| 15-0 | 72 ho | eted | 15. Decedent's Education (Specify only highast grade completed) (Give kind of ville. DO NOT | | | | | | | ipation a during mos | at of work | ing | 16b. H | (ind of B | usiness/ir |
| 2121 | withir lene. then | ompiete | Elementary/Sec | condary (0-12) | Collaga | (1-4or 5+) | III | ө. <i>DO NOT</i> u Тэхсг | | | | | | | D. |

 Birthpiaca (Steta or Foreign Country) 1916 New York

Anne-Arundel

3. Tima of Death

2:40pm

10d. Inaide City Limits 1 ☐ Yes 2 No

110 Wallace Avenue 21225 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 XIXo If Yes, Give Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Never Married ※ Married 1 ☐ Yes 2 CNo Specity: White Specify: 3 ☐ Widowed 4 ☐ Divorced

9th N/A Tavern Owner Bar 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Sumeme)

Nicholas Mackowski Sabina SaSadeuze 19a. Informant'a Neme/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

110 Wallace Avenue, Baltimore, MD 21225 20b. Piace of Disposition (Name of cematary, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial ②Coremation 3 ☐ Ramoval from Stata Green Mount Crematory Feb. 16, 1996 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City

21. Signature of Futural Service Lie 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc.

23a. Peril. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onsat and Death

immediate Cause (Finei disaasa or condition resulting in death) EMPHYSEMA CHRONIC BRONCHITIS MANY YRS

Due to (or as a consequence of)

Julia M. Mackowski/Wife

LUNG 22AM 3 YRS Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last

Dua to (or as a consequence of):

Part Ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown BERCULUSIS

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 Dr No 1 ☐ Yes 2 ☐ No

25. Was case referred to medicai 26. Piace of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 没知 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2ENo

27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 5 Panding investigation

1 Neturai 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

XIX Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiar (Check only one)

Medical 29b. Signature and title of dartill 29c. Licanse number 29d. Date signed (Month, Day, Year)

D18267 February 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kamal Batcha 1600 South Crain Highway, Suite-308, Baltimore, Maryland

State Registrar

Completed

Be

filed within 72 hours aftar

I Health and Mental Hyglene.

Physician

/Medical

Examiner

physician and s the burial-transit

esn

8 8

page 2

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within 24 hours after deat To the Funeral Director: completely filled in by the

The law requires that the death certificate be asscuted

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

To the

death.

Examine

Physician/Medicai

þ

Completed

Be

2

Certification:

4 Homicide

and 2 should be

Maryland 21215-0020

and the second of the second o

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| | | | | State of M | arylan | | artment <i>rtificate</i> | | | Mental Hy | giene S Reg. No. | 16 | 03331 | | |
|------------|---|---------------------|---|--|----------------------------------|----------------------------------|-----------------------------|--------------------------|------------------------------|--------------------------------------|------------------------------|--|--|--|--|
| | Physic | | Decedent's Neme (First, Middle, Last, MILDRED C. | | 2. Dete of De Month FEBRUA | Dey | Year 1996 | 3. Time of Deeth 7:30 PM | | | | | | | |
| | /Medi Exami | | 4e. Fecility Name (If not institution, giva | street and number) | | | | 4 | lb. City, Town, or | Location of Deet | | | 7.50 111 | | |
| | | | 2503 LAKELAND AVE | NUE | | | | | BALTIMOR | E | BALT | IMORE | ECITY | | |
| | Funeral | Г | 5. Sociel Security Number 6. Sec | | e (in yrs. | last birthday) | If Under | Yaar Deys | If Undar 24 Hrs Hours Min | | th Voar | 9. Birthp | placa (Stata or Foreign | | |
| | Director | | 213-09-8513 |]M 2∏ F | 83 | Yrs. | WORKIS | Doys | Tiours Will | | , 1913 | | | | |
| | Pul | | Usuel Residence of Decedant 10e. Stete 10b. County | | 10c Cit | y, Town or Lo | cation | | | | | | Od Jacks Ob. History | | |
| | aryla | 2 | MARYLAND BALTIMOR | E CITY | | | | | | | | [1 | 0d. Inside City Limits 1X Yes 2 □ No | | |
| | he N | ecto | | E CITI | DA | LTIMOR | _ | | | | ••• | | | | |
| | with o | ក់ | 10e. Street end Number | MILE | | | 10f. Zip | | 20 | | | | itry? | | |
| | eath | era | 2503 LAKELAND AVE | NUL 12. Was Decedent | Ever in 11 | S 12 1 | Was Danad | 212 | | Considu Vac or No | | | en Indian | | |
| 0 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be incurred. | by Funeral Director | 1 Never Merried 2 Merried | Armed Forcas? | | | | | | Specify Yas or No to Rican, atc.) | | ick, Whita, | atc. | | |
| 00 | ral'. | l by | 3 ☐ Widowed 4 🛣 Divorced | If Yes, Give 12 Year or Dates: | | | 1 ☐ Yes 2 | X NO | Specity: | | Speci | y: WHI | TE | | |
| 21215-0020 | 72 h | Completed | 15. Decedent's Edu (Specify only highest grade | cation a completed) | | 16a. Dece | dent's Usuel | Occup | dustry | | | | | | |
| 121 | Pan ilhin | du | Elementery/Secondary (0-12) | College (1-4or 5 | i+) | | | | during most of wo | 9 | | m 4 = T | 0.17.70 | | |
| 12 | filed with Hygiene. ther than | | 12TH GRADE | | | SAL | ES CL | ERK | | | | g. Citizen of Whet Country? U.S.A. 14. Race - American Indian, Biack, Whita, atc. Specify: WHITE Sb. Kind of Business/Industry RETAIL SALES aiden Sumame) ER City or Town, State, Zip Code) RE, MD 21230 Dc. Location - City or Town, Stete BALTIMORE | | | |
| and | d off | Be | 17. Fether's Nema (First, Middle, Last) | | | | | | | | | Maiden Surname) | | | |
| Maryland | 2 should be fi and Mental I is marked of raumatic ever | To | JOHN A. COLLINS | | | 1 | | | | STEINBAC | | | | | |
| Mai | l 2 sh n and ls m | | 19e. Informent's Name/Reietlonship (Ty | pe, Print) | | | | | | | | | | | |
| | 1 and 3 Health em 27 i | | VAL MENEFEE | | 205 5 | 1 | | | | - BALTIM | | | | | |
| 0 | Pages 1 nent of H nrt: If ite iry or off | | 20e. Method ot Disposition 1 ☐ Buriel 2 ☐ Crametion 3 ☐ R | emovel from Stete | 200. F | Plece of Dispo cematary, crem | natory or of | her plac | :0) | Dete | 20c. Location | - City or 10 | wn, Stete | | |
| Ħ | tmer tant | | 4 Donetlon 5 Other (Specify) | | W | ESTERN | | | | 2/15 | BALTIM | ORE | | | |
| Baltimore, | permit. Page Department of Important: If eny Injury or once. | | 21. Signatura of Funerel Servica License | 1 | | | | | ss of Fecility [ERAL HO] | ME, INC. | | | | | |
| | | | 1. They Col | anal | | 41 | 07 WI | KEN | S AVENU | E-BALTIM | | 212 | 29 | | |
| | | | 23a. Part1. Enter the diseese, or compli shock, or heert teilure. List only or | cations thet caused ne ceuse on eech li | I the deet ne. | h. Do not ent | er the mode | of dyln | g, such es cerdie | c or raspiratory a | rrest, | i | interval Between | | |
| | Physician / /Medicai | | Immediete Ceuse (Final | | | - | | \ | 1 | | | 1 | Onset and Death | | |
| | Examiner | | disaesa or condition rasuiting in deeth) | . Ca | RCI | nom | 9 | 14 | wif | | | | 3 year | | |
| | 135-1 | -e | | | Due to (c | or es a consec | quence ot): | Υ., | 1 1 | | | i | 0 | | |
| | ned insit | Examiner | C t |). | -XP | mai | - | M | stasto | isis | | i ' | 6 minus | | |
| , | n enc | Exa | Sequentially list conditions, if any, leading to immediate | | Due to (o | or as a consec | quence of): | | | | | 1 | | | |
| 68760, | icate be executed physician end s the bunal-transit | dicai | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events | | Dua to /a | | wansa offi | | | | | | | | |
| _ | death certificate be executed e ettending physician end of for use es the bunal-transit | P | resulting in death) Lest | | Due to (o | r as a conseq | derice oi): | | | | | | | | |
| Box | eath certific ettending p | 2 | d | l | | | | | | | | | | | |
| | the ette | Physiclan/Me | Pert II. Other eignificant conditions con | tributing to death b | ut not res | ulting in the u | nderivina ca | use giv | en in Pert I. | 23b. Did | tobacco une ci | ontribute to | the cause of death | | |
| P.0 | 5 >0 | بۇر | mb | 0- | - | - | | | | | Yee 2□ No | | bably 4 Unknow | | |
| Ś | | þ | Nype | erlen | n | _ | | | | | | | | | |
| ord | v requires been sign should be | | (-1-1 | | | | | | | | an autopsy | 24b. W | ere eutopsy findings allable prior to | | |
| Record | 2 S | Completed | | | | | | | | | | | mpletion of cause death? | | |
| | 0 - 0 | ě | | | | | | | | 10 | Yes 20 No | 10 | Yes 2 No | | |
| Vital | Iclan: The certificate rector, pag | Be (| 25. Wes casa raferred to medical exeminar? | | | | | | 28. Placa of De | eth (Check only | one) | | | | |
| of V | \$ 50 D | 2 | 1 Yes 2 No | lospitel: 1 🗆 Inpatie | nt 2 🗆 | ER/Outpatier | at 3□ DO | Oth | er: 4 Nursing | Home 5 Aasl | dence 8 🗆 Ot | her (Specif | y) | | |
| | | | 27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending | 28e. Dete of Inju (Month, Da | y Year) | 28b. Time of Injury | 28 | c. Injun Worl | at k? | 28d. Describe | how injury occu | rred | | | |
| Sio | | catio | 2 Accident investigation | | | | M | | Yes 2□No | | | | | | |
| Division | | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e, Place of Injusting, etc. | ury - At ho . (Specifi | ome, ferm, str | eat, fectory, | office | | 28f. Location (City or To | Straat and Num wn, State) | ber or Rura | il Route Number, | | |
| _ | lospital t hours a uneral f | | 29e. Certifier 1☑ Cartifying Phys | ician. To the heet | of my know | wledge deeth | occurred a | t the tim | a data and nice | and due to the | course(s) and m | ennor oe ei | totad | | |
| | To the Hospital or thin 24 hours aft to the Funeral Dis compietaly filled in | edical | (Check only 2 Medical Examination) | end menner sta | examine | tion end/or in | vestigation, | n my o | olnion, deeth occ | urred et the time, | date and place, | and due to | the cause(s) | | |
| | to this | Σ | 29b. Signetura and titla of certitier | 1c 1 | | | 29c, | Licens | e number | | 29d. Date sign | ed (Month, | Day, Year) | | |
| D | 1)_ | | Kam o | Kary | m | <u></u> | | Do | 2630 | 7 | 2/13 | 196 | | | |
| - | 1 | | 30. Name end eddress of person who co | V | | | | 0.470 | arra- | 100 5 | AT MTMOS | E 340 | 01007 | | |
| | | | DR. RANI S. KARIP | INENI - 4 | UUU | ANNAPO | PT2 K | UAD | - SUITE | 103 - B | MLIIMUK | r, ML | 21227 | | |

State Registrar

the first of the state of the section of the sectio

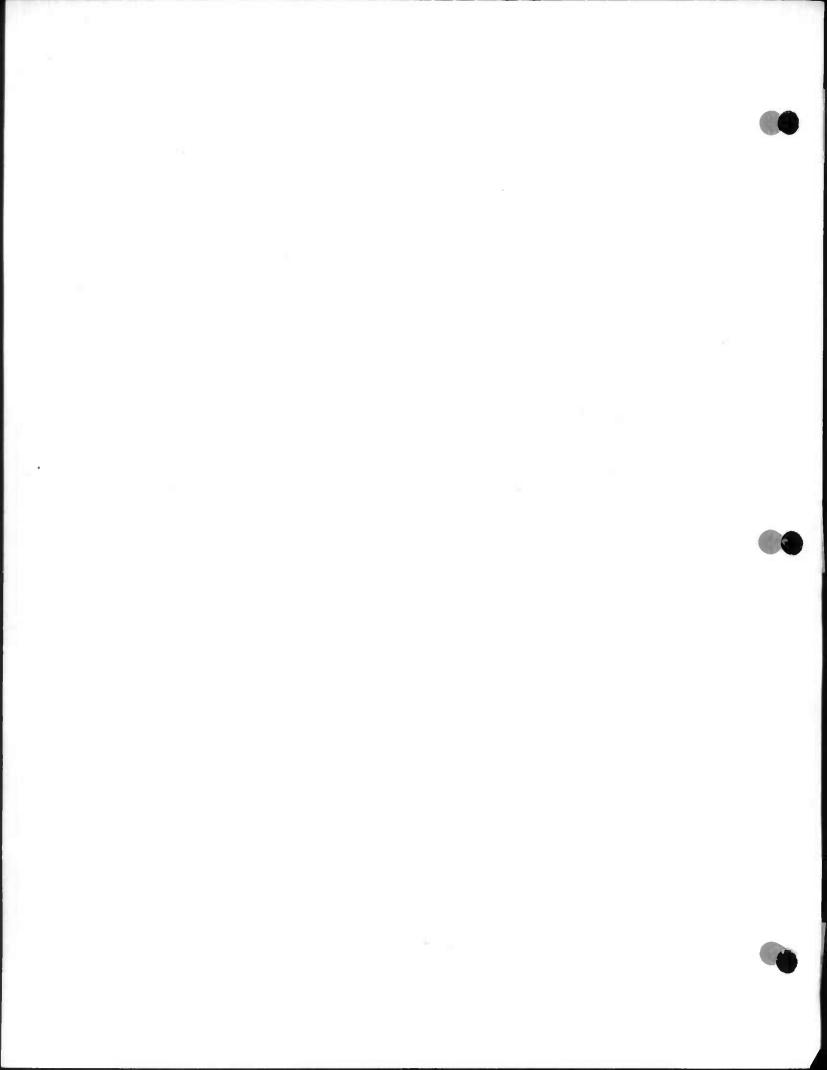
| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. |
|--|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | | | HEALTH AND | MEN | TAL HYGIEN | E | | | |
|------------------|--|--|------------------|--------------|----------------------|--|----------|---|--------------------|-------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle JAMES G. MORA | ,, | | | | | M | DATE OF DEATH | | YEAR | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. las | | | | | BRUARY 9 | , 1 | 996 | 8.05 A M | |
| | 212-14-8388 | | 74 | YRS. | MONTHS DAY | | - 0 | Month, Day, Year) | ., | Countr | IPLACE (State or Foreign | |
| | 9a. FACILITY NAME (If not institution | | 74 | Tho. | at CITY TOW | N OR LOCATION OF | | EC 28,19 | | | Ö.,MD | |
| Œ | ATLANTIC GENE | | | | | | DEATH | | | NTY OF D | | |
| 2 | RESIDENCE OF DECEDENT | | | | OCEAN CITY WORCESTER | | | | | IEK | | |
| DIRECTOR | | COUNTY | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? | |
| | | WORCESTER | | | OCEAN | CITY | | | | | 1 TES 2 NO | |
| 3AL | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | | 10g. CITI | ZEN OF V | WHAT COUNTRY? | |
| FUNERAL | 12 50TH STREET | | | | | 21842 | | | | .S.A | • | |
| E | 11. MARITAL STATUS 1 Never Married 2 X Marrie | 12. WAS DECEDENT EV | ER IN U.S. AR | MED IO | 13. WAS E | ECENDENT OF HISF specify Cuban, Mex | PANIC OF | RIGIN? (Specify Yes erto Rican, stc.) | or No- | 14. RACE Black | E — American Indian, k, White, etc. | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR O | W II | | | ES 2 NO Spe | | e-miss. 10 | | Speci | WHITE | |
| | 15. DECEDENT | I'S EDUCATION | | CEDENT'S | USUAL OCCUPY | TION | | 18b. KIND OF BUS | INESS/INC | HISTOY | WILLE | |
| | (Specify only highe Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (G | Do NOT us | work done during | most of working | | | | | | |
| F | 9TH GRADE | conege (1-4 or 5+) | | SAL | ES | | ı | SEL | F-EM | PLOY | ED | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, L | (ast) | | | | 16. MOTHER'S I | NAME (F | irst, Middle, Maiden | Sumame) | - | | |
| BE | JAMES G. MORAN | ,SR. | | | | PEARL | CHR | ISTOPHER | | | | |
| 10 B | 19e. INFORMANT'S NAME (Type/Pris | · | | | | et end Number or Run | | | | | | |
| | MARGUERITE MOR | | 1 | 2 50 | TH STRE | EET - OCE | AN | CITY, MD | . 21 | 842 | (UNIT-104) | |
| | 20a. METHOD OF DISPOSITION 1 Duriel 2 N Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of comatery, crematory or other place) | | | | | | | | | | wn, Stata | |
| | HILLTOP SERVICE CORP. 2/14/96 TOWSON | | | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. | | | | | | | | | | | |
| | Alelsa Hug Hubbard Funeral Home, Inc. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | | | | | | | | | |
| | 23. PART I. Enter the disease | ea, or complications that ca eliurs. List only one cause of | used the de | ath. Do r | not enter the | mode of dying, sa | uch ss | cardiac or reapli | ratory arr | eat, | Approximata | |
| | IMMEDIATE CAUSE (Final | | | | | | | Interval Between Onset and Death | | | | |
| | disease or condition resulting in death) | | | 2NCer | | | | | | | 6 MENTES | |
| | disease or condition resulting in death) a. UN G CONCEIR DUE TO (OR/AS A CONSEQUENCE OF): | | | | | | | | | | | |
| N | Sequentially list conditions, | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| 원 | CAUSE (Disease or injury that initiated events | C. DUE TO (OR | AS A CONSEC | DUENCE O | FI: | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | i | |
| CE | | d | | | | | | | | | | |
| AL | PART II. Other significent con | nditions contributing to dee | th but not r | esulting | In the undarly | ing cause given | In Part | I. 24a. WAS AN A | | 24b | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| 8 | | | | | | | | 1 TYES 2 | | | COMPLETION OF CAUSE OF DEATH? | |
| ME | | | | | | | | | | | 1 YES 2 NO | |
| ž | | ONTRIBUTE TO CAUS | | | | | IN [|] | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER: | | | | | | | | | | | |
| IYS | 1 VES 2 NO 1 No Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | |
| | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | |
| BY | 2 Accident Investigation 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At hor building, etc. (Specify) | | | | M 1 YES 2 NO | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| COMPLETED | | | | | | | | | | | | |
| | 29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| MP. | | XAMINER: On the basis of exemin | | | | | | | | | | |
| | | | and/of I | veatigm(10 | , чт пу ориног | | | uste end piece, and | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | (Month, Day, Year) | | | |
| ဥ | 30. NAME AND ADDRESS OF PERS | SON WHO COMPLETED CAUSE OF | E DEATH ATE | 4 27) /5~- | Delett | 1444 | 28 | 2 | -2 | 191 | 46 | |
| | ROBERT | OUP-1CID 433 HEALTH | . A. | n erj (lype, | A C | | 00 | RLIN | | 2 | | |
| - 11 | 7 | TOO ITEMLTA | TW/TU | | 111/2/1/8 | | 15 8 | 1-6/N | 1/1/2/ | 1 | | |

31. DATE FILED (Month, Day, Year)
FFB 1 5 1996 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

BERLIN MO



Pages 1, 2, 3 should

1501

31. DATE FILED (Month, Day, Year)
FEB 1 5 1996

| physician. | TO THE FLINETAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permitted to the complete of the complet | • | |
|---|--|----------------------|--|
| spital or attending | hed for use as the | | |
| retained by the ho | 5 should be detact | | notified at once |
| 1. Page 6 may be | iral director, page | | liner must be r |
| 4 hours after death | illed in by the fune | n, or removal. | e medical exam |
| executed within 2 | and completely i | to burial, crematio | matic event, th |
| leath certificate be | attending physicia | ntal Hygiene prior | y, or other trau |
| requires that the c | een signed by the | of Health and Me | shows any inju- |
| IYSICIAN: The law | is certificate has b | ith the State Dept | ed, or Hem 23 |
| OR ATTENDING PH | INSCREEN After th | ours after death w | em 28 is mark |
| TO THE HOSTITM, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, | D THE FUNERAL T | e filed within 72 h. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| - | - | Δ | = |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Leat) 2. DATE OF DEATH 3. TIME OF DEATH MOODY COLUMBUS HERBERT 1996 8:00 P. M FEB. 06 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. leat birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Country) (Month, Day, Yea 55 DAYS 216-36-6614 1 🔀 M 2 🗌 F YRS. 1940 MARYLAND Sa. FACILITY NAME (If not institution, give atreet and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE CITY 6301 MONIDA PLACE N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? N/A MARYLAND BALTIMORE CITY XX YES 2 NO 10e, STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1400 W. SARATOGA STREET 21223 USA. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify BY Specify: 3 - Widowed 4 X Divorced BLACK COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY 10th GRADE College (1-4 or 5+) LANDSCAPING COMPANY LANDSCAPER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumeme) ISABELLE MOODY ANDERSON WILLIAM BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 2311 W. LANVALE STREET, BALTIMORE, MD. 21216 MOODY DORIS 20e. METHOD OF DISPOSITION
1)() Burlel 2 Cremetton 3 Removal from State
4 Donatton 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE . ZION CEMETERY 2-10-96 BALTIMORE, MARYLAND OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 23. PART i. Enter the disesses, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each Interval Between Onset and Death IMMEDIATE CAUSE (Final disesse or condition_ 115ton 0 resulting in death) DUE TO (OR AS A CONSEQUENCE OF) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate loutr e. Enter UNDERLYING a CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPS) 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 -DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(e) end ma 29b. SIGNATURE AN TLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED /Mo BE 10 2

Health

core

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 0400 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Veer **Physician** DOROTHY MARTINDELL 13, FEBRUARY 1996 9:20a /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A If Undar 1 Year | if Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year, 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (Stata or Foraign Country) Days 1 □ M 2 1 F Months Hours 561-22-3141 78 Jan 6, Director 1918 Illinois Usual Rasidance of Decedant with the Maryland 10b. County 10c. City, Town or Location Bhow 10d. insida City Limits r than "natural", or items 23a or 28a-f ahor The Medical Examiner must be notified at Director 1 Yas 2 No Baltimore Edgemere 10s. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7325 Waldman Ave 21219 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2X No if Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 14. Race - American Indian Black, White, atc. filed within 72 hours after 1 Navar Married 2 Married 21215-0020 1 Yas 2 No Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Year or Dates Completed 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest greda complated) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Eiamentary/Secondary (0-12) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 is marked other th any Injury or other traumatic event, the Nurse Hospital Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Malden Sumama) Be Theodore Bergbower Emma Wemmer 19a. informant's Name/Raiatlonship (Type, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Walter Martindell/husband 7325 Waldman Ave Baltimore, Md 21219 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Holly Hill Memorial 2/17/96 Baltimore, Md 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funarai Sarvice Licensaa 22. Nama and Addrass of Facility
Connelly Funeral Home of Dundalk Colt Inthony (onn 7110 Sollers Point Rd 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata interval Batween Onsat and Death **Physician** SLY /Medical immediata Causa (Finai · CONGESTIVE HEART MONTHS FAILURE disaasa or condition rasuiting in daath) **Examiner** Dua to (or as e consequence of): TEN YEARS MITRAL REGUROITATION Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and the buriel-tran Dua to (or as a consequence of): TWELVE ARTERN c. CORONARY DISEASE 4 CARS Physician/Medical Dua to (or as a consequence of) signed by the e Part ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The lew requires that CHRONIC RENAL INSUFFICIENCY þ 24b. Wera autopsy findings available prior to completion of causa of daath? Completed 24a. Was an eutopsy SYNDROME SINUS SICK hes certificate 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital director, 25. Was case rafarrad to medical axaminar? Be 26. Piaca of Death (Check only ona) Hospital: 1 Annatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No this funeral 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred After Attending 1 Natural 5 Panding invastigation after death.

Director: Aft
d in by the fur 1 Yas 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Sulcida 28a. Piace of injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide ò filled in To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta end piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, deta and place, and due to the cause(s) and manner stated. edical 29a. Certifiar npletely (Check only one) 29b. Signature and title of ceptiles 29c. Licansa number 29d. Data signed (Month, Day, Year) Physician N2600 FEBRUARY 13, 1996 30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print) Jothn'S Ho PKINS HOSPITAL SYDNEY EILEEN MORSS TOWER 110 BALTIMORE, MARYLAND 21287 31. Date filed (Month, Day, Year) FEB 1 5 1996 22. Registrar's Signatura State

Registrar

